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ABSTRACT

This handbook on preventing child abuse is intended to help families with young children, especially young children who have or are at risk for disabilities, and to help people working with such families. After an introductory section which presents basic definitions, the first chapter presents highlights of the Education of the Handicapped Act Amendments of 1986, especially Part H (Programs for Infants and Toddlers with Handicaps) and Part B (the Preschool Grants Program). The next chapter defines child maltreatment and identifies risk factors, including increased risk for a child with disabilities. The third chapter outlines normal child development and indicators of physical, emotional, or sexual abuse in infants, toddlers, and preschoolers. Discussed in the fourth chapter is how to talk to a young child when abuse is suspected (especially sexual abuse) and requirements for reporting maltreatment. Prevention of child maltreatment is considered next including primary, secondary, and tertiary prevention strategies and child abuse prevention checklists. An additional chapter examines effects of parental substance abuse on infants and includes discussion and resources concerning Fetal Alcohol Syndrome, effects of cocaine and crack on children, and Acquired Immune Deficiency Syndrome. An extensive resource list includes hotlines, resources for teaching young children about abuse, and additional resources for professionals and families. (DB)

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LET'S PREVENT

ABUSE

A Prevention Handbook For Early Childhood Professionals and Families with Young Children

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LET'S PREVENT ABUSE

A Prevention Handbook for Early Childhood Professionals and Families with Young Children

with Special Emphasis on the Needs of Children with Disabilities

Prepared by PACER Center

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Original drawings created especially for PACER Center by Toni Parrish

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Sometimes in summer when
the radio was on
I'd dance with the music in the backyard,
turning and leaping, hands and feet
cutting through the air,
then falling into the grass, I'd lay sweating
and drowsy in the sun,
dreaming about being beautiful.

Now ghosts climb over my shoulders.
I have nightmares with my eyes open
and know all the people in them –
know their smells and the dangers
and how it was my fault,
yet staying silent because
even if I could say the words,
there is no one to tell but them.

–As remembered by an adult
survivor of child abuse

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Introduction

Federal Agencies

National Center on Child Abuse and Neglect
Children's Bureau
Administration for Children, Youth,
and Families
Office of Human Development Services
P.O. Box 1182
Washington, D.C. 20013
(202) 245-0813

NCCAN (National Center on Child Abuse
and Neglect) Child Abuse Clearinghouse
Aspen Systems
P.O. Box 1182
Washington, DC 20013
(703) 821-2086

Introduction

Preventing Child Abuse: How Can We Help?

Stories about children who are brutally abused are sensationalized frequently in the media. Available statistics indicate that only two percent of the children abused receive major physical injuries that result in death. Yet in acknowledging child abuse and maltreatment, we often refer to only those two percent of children who die. In 1988, the National Committee for the Prevention of Child Abuse cited over 2.4 million reports of child abuse and neglect annually. These incidences were only the reported incidences. Many clinicians believe the numbers are much greater for nonreported cases.

If we are to reduce the maltreatment of children, we must create a safe environment for families. We must build communities where children and adults can express their fears and needs without shame and receive the acceptance, support, resources, and knowledge that will result in empowerment. We can help reduce maltreatment when we accept responsibility for acts against children and are willing to respond quickly with the resources and support needed.

This handbook is specifically designed for people who work with children ages birth through five years and their families and also for families with young children, especially young children who have or are at risk for disabilities. PACER is an organization which advocates on behalf of children with disabilities and their families.

What Do Families and Professionals Need to Know?

As a parent or primary caregiver, you will find that most of the information in this handbook is written for early childhood professionals. You will, however, find the information useful as background about child maltreatment: what it is, how to avoid it, how to report it, and the types of services and resources available. If you are placing your child in daycare, the information in the chapter about prevention of child maltreatment will be useful in choosing a child-care center that has written policies and guidelines for the prevention of child abuse.

As an early childhood professional, it is more than likely that you will work with an abused or neglected child. Your role in working with maltreated children will vary according to individual circumstances. Whatever your specific role, you will be faced with challenges and questions you may not feel prepared to handle. PACER Center's LET'S PREVENT ABUSE Project hopes this handbook will assist you in identifying the early signs of maltreatment, what your responsibilities are in reporting possible maltreatment, as well as providing you with some resources to assist families in gaining additional support when needed—before a child is harmed.

Definitions

Young children. For the purposes of this publication, we refer to young children as:

- **Infants:** Newborns and children to the age of 18 months
- **Toddlers:** Children ages 18 months through 2 years
- **Preschoolers:** Children ages 3 through 5 years

Caregiver. In the context of this handbook, a caregiver is any person responsible for meeting a child's needs. In addition to a parent or parents, a caregiver, by federal law, may include an employee of a residential facility or any staff person providing out-of-home care.

Early intervention. According to Part H of Public Law 99-457—which is discussed in the following chapter—early intervention means finding and providing services for infants and toddlers, children birth *through* two years of age who are experiencing developmental delays. The term may also include, at a state's discretion, children from birth through age two who are *at risk* of having developmental delays if early intervention services are not provided.

Empower, empowering, empowerment. In this handbook, we use the word "empower" in several different ways. In the chapter about reporting maltreatment, you will find "empower" used in the form closest to dictionary definitions: "to invest with legal power; authorize."

In several chapters, however, we also refer to "empowering" children and families. As professionals you can empower children and families by investing them with power to use their right to services guaranteed by law. But by "empowering" we also mean the process of "empowerment."

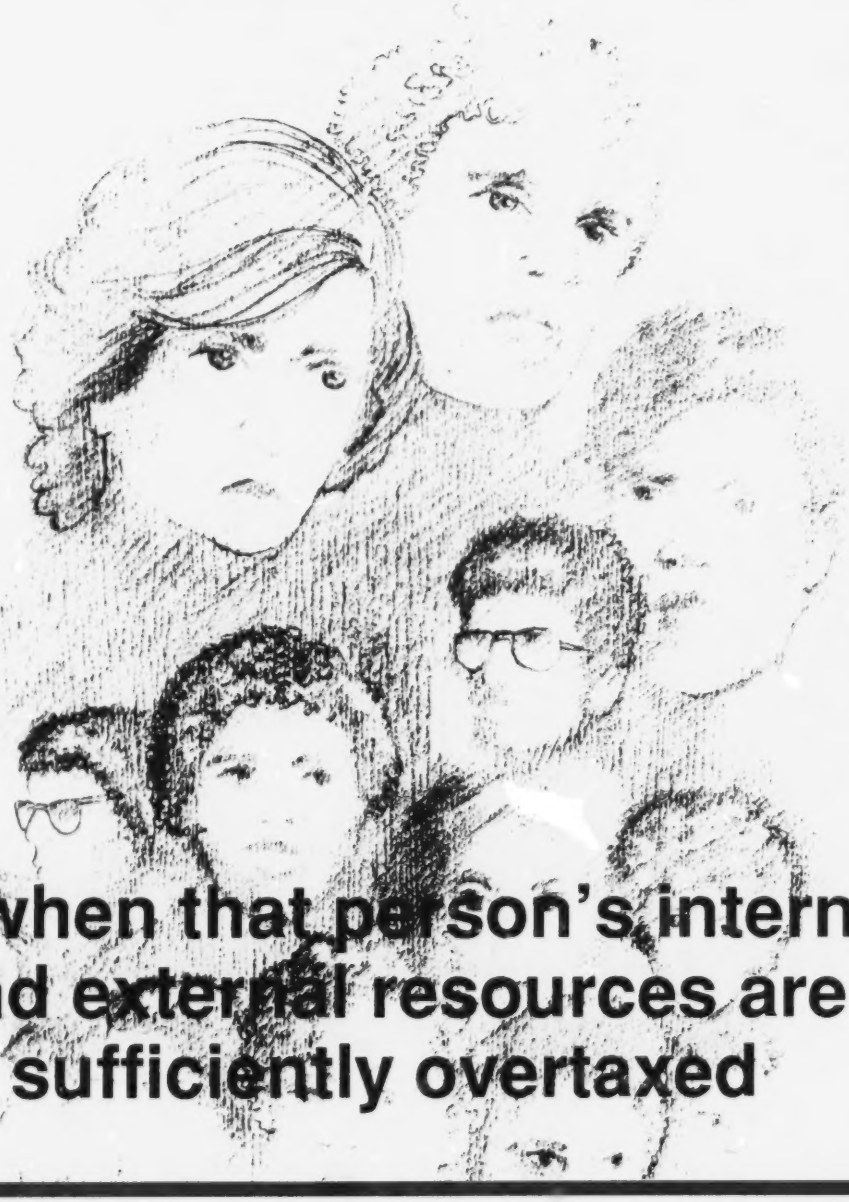
What is empowerment?

- Empowerment is the process of discovering within ourselves and in others the capacity to make change.
- Empowerment is the discovery and unlocking of individual power, not for oppression, but for new ways of thinking and acting.
- Empowerment is moving from anger and fear to action.
- Empowerment is creating life-giving human priorities in our personal, political, and professional lives.
- Empowerment is information, support, and encouragement; empowerment is saying, "I believe that you can do it."

Where Does It All Begin?

To understand child maltreatment, society needs to know and understand that each of us is capable of acting out against children if our internal and external resources are sufficiently overtaxed. Until we as a society accept this concept. it is easy to allow the issue to be someone else's problem. It is very likely that within our life spans, we, as individuals, will become familiar with the effects of child maltreatment in one form or another. It may be through a friend, a relative, or even our own children, that we as individuals experience the devastation child maltreatment can and does produce.

EVERYONE is capable of acting out against children . . .



. . . when that person's internal and external resources are sufficiently overtaxed

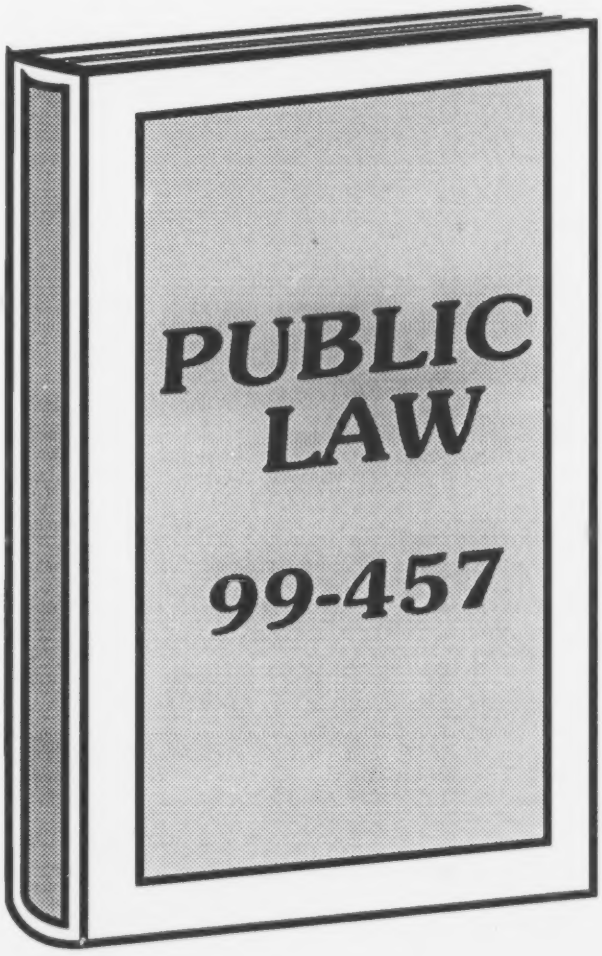
What About the Future?

Child maltreatment is a complex and multifaceted problem. As parents and professionals, we need to recognize that child maltreatment affects much more than the individual child, for it is a problem of, and has an impact upon, our society as a whole. There is no one solution to child maltreatment, and no one discipline, agency, or institution should be required or asked to address the problem independently, since child abuse crosses all segments of society, and therefore involves all institutions, agencies, and disciplines.

Prevention of child maltreatment requires that various disciplines, institutions, and agencies work together in cooperating to provide prevention and intervention strategies that help families and individuals who are caught in the destructive cycle of abuse. The strategies for prevention in this handbook are designed to help children and families. Breaking the destructive cycle of child abuse in our culture will require all our efforts as individuals, parents, family members, and professionals. □

References – Introduction

National Committee for the Prevention of Child Abuse (NCPCA). (March, 1988). *Child Abuse Fatalities Remain High: The Results of the 1987 Annual Fifty State Survey* (Working Paper Number 8, P. 3). Chicago, IL: Author. (Available from NCPCA, Publishing Department, 332 South Michigan Avenue, Suite 1600, Chicago, IL 312/663-3520.)


PUBLIC
LAW
99-457

Public Law 99-457: The Education of the Handicapped Act Amendments of 1986

In October of 1986, Public Law 99-457 (PL 99-457), the amendment to the Education of the Handicapped Act (EHA*) was signed. PL 99-457 established a national policy for young children with disabilities and developmental delays and their families. Some of the types of programs included under the law are research, training, educational technology, demonstration and outreach projects, as well as evaluation and technical assistance. Two major parts of the law, Title I, or Part H, and Title II, or Part B (Part B is an amendment to Section 619 of the EHA) address the education and special needs of children birth through five years of age who have or are at risk for disabilities. The implementation of PL 99-457 is scheduled to take five years. States are still in the process of developing and implementing the comprehensive, statewide services described in PL 99-457; many states are still in the initial stages.

Highlights of Part H: Programs for Infants and Toddlers with Handicaps (birth through age 2 years)

Under Part H, states would be provided federal funds for the following:

- Planning, developing, and implementing statewide comprehensive, coordinated, multidisciplinary, interagency programs of early intervention services.
- Facilitating coordination of services and payments from public and private sources.
- Enhancing the capacity of states to provide quality early intervention services and to expand and improve existing services.

These statewide systems are intended to address the needs of infants and toddlers who are experiencing developmental delays, or a diagnosed physical or mental condition with high risk for developmental delays, in one or more of the following areas: cognitive development; physical development, including vision and hearing; language and speech development; psychosocial development; or self-help skills. States have the option to define and serve "at-risk" children in these areas.

Services must be provided under public supervision, meet state and federal standards, be provided by qualified personnel, and meet the needs of children in the five delay areas listed above. Services include, but are not limited to, family training and counseling, special instruction, speech pathology, occupational and physical therapy, case management, and medical screening, evaluation, and diagnosis.

Part H specifies that the following areas of service be developed:

- A central directory of early intervention and early childhood services to be developed and distributed.
- A timetable for development of early intervention services.
- A public awareness program.

*Congress has recently changed the name of the EHA to IDEA (Individuals with Disabilities Education Act.)

- A comprehensive, multidisciplinary child-find system.
- A system that includes timely, comprehensive, and multidisciplinary evaluation and assessment of the child and the child's family.
- A program of nondiscriminatory procedures that recognizes racial and cultural diversity and provides for communication in the parents' native language.
- An Individualized Family Service Plan (IFSP)* The IFSP must include seven major parts:
  1. Multidisciplinary assessment and identification of appropriate services.
  2. A written IFSP by a multidisciplinary team and with parent or guardian.
  3. Early intervention services, with consideration of frequency, intensity, and method of delivery.
  4. Expected outcomes for child and family.
  5. Projected dates for services.
  6. A case manager named from the most relevant profession for the child's needs.
  7. Transition to Part B services (special education and related services beginning at age 3).
- A comprehensive system of personnel development.
- Procedural safeguards and assurance of their effective implementation.

* What Is an IFSP?

An Individualized Family Service Plan (IFSP) defines the services to be provided to the child with special needs and the child's family. A multidisciplinary team, which includes parents, creates the written IFSP. The IFSP must be reviewed annually.

The IFSP is centered on the entire family's needs rather than only the needs of the child with a disability. The IFSP should include information about the child's present functioning in the area of physical development, language and speech development, cognitive development, psychosocial development, and self-help skills.

The IFSP should also include the family's strengths and needs related to helping the child's development, the specific early intervention services necessary to meet the unique needs of the child and family, location, frequency, and method of services, payment arrangements, and timelines.

Highlights of Part B: Preschool Grants Program (ages 3 through 5 years)

Under Part B, federal funding creates incentives for states to provide a free, appropriate, public education (FAPE) to all eligible children with disabilities ages 3 through 5 years of age by the 1990-1991 or 1991-1992 school year.

The characteristics of Part B include:

- The Individualized Education Program (IEP), a plan similar to the IFSP except that it includes only the child's special education needs. Under Part B, however,

the family is recognized as having an important role in preschool programs; services (such as training and counseling) are to be made available to families.

- Due process.
- Confidentiality.
- Least restrictive environment (LRE) (which means that special education services for special needs children should be carried out in regular classrooms and schools to the fullest extent possible).
- Community services, home- or center-based, may be implemented directly by the state or through contracts with other service agencies.

Significance for Parents

What does this new law mean for parents of young children?

Once PL 99-457 is implemented, more mental and physical health, education, and related resources and programs will be available for parents of young children. (In Minnesota, for example, early childhood family education classes are offered free or at very low cost to all families through community education programs throughout the state.)

In addition, the IFSP (for very young children with special needs and their families) and the IEP (for children 3 through 5) will help families plan and provide for their child's education and future.

Significance for Early Childhood Professionals

What does this new law mean for early childhood professionals?

If you are an early childhood special education teacher, you may:

- Be asked to provide case management for a family who has a preschool child in need of special services.

If you are a head teacher or child-care provider in a preschool or daycare setting, you may:

- Provide respite care to parents, which may allow them to experience social interactions with others or simply to rest and have time to care for themselves.

If you are a teacher in a Head Start program, you may:

- Observe the child's development and participate in assessment and referral to other programs for further needs.

What can early childhood professionals do?

The most supportive role to play in empowering families is to assist them to recognize the strengths in their families and allow them to identify their own needs.

In all of the above roles, you may be a team member participating in the preparation and implementation of an IFSP or IEP for a child with special needs.

Why Is This Law Significant for the Prevention of Child Maltreatment?

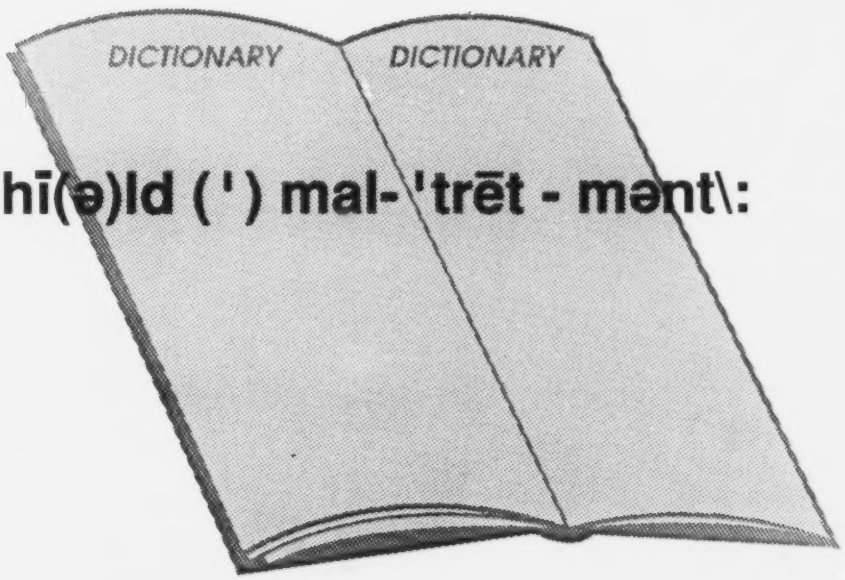
First, with the identification of at-risk children, states will be able to provide early intervention services and resources for families and children. Second, families will have access to resources for both parents and children in the prevention of maltreatment. These resources are particularly important for children and their families who live in poverty and for children with or at risk for disabilities and their families. Factors such as stress and poor self-image are critical issues in many kinds of child maltreatment, as is the need for access to supportive resources.

The strong emphases on families on the one hand, and the development of comprehensive and community-based early childhood systems and interagency cooperation on the other, differentiate PL 99-457 from previous legislation. □

References – Public Law 99-457

Trohanis, P. L. (1989). An Introduction to PL 99-457 and the National Policy Agenda for Serving Young Children with Special Needs and Their Families. In J. J. Gallagher, P. L. Trohanis, & R. M. Clifford (Eds.), *Policy Implementation and PL 99-457: Planning for Young Children with Special Needs* (pp. 1-17). Baltimore, MD: Paul H. Brooks.

Child Maltreatment



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Definition and Risk Factors

Children have the right to be safe . . .

What Is Child Maltreatment?

Whether specific maltreatment is physical, sexual, verbal, or neglectful, the common underlying factor is a lack of emotional support and encouragement for the child and the lasting effects of that lack of support on the child's sense of self, expectations for others, and resources for coping with life challenges.

— Martha Farrell Erickson, PhD

Child abuse and neglect have no socioeconomic, demographic, religious, or cultural boundaries. It can happen in *ANY* family. For many children it is an everyday occurrence. No matter which type of abuse or neglect occurs, everyone involved loses, and society pays an enormous price. According to a recent *Fact Find* from the Center for Early Education and Development at the University of Minnesota, the lifetime cost of care for each abused child can be as much as $2,273,342. This estimate does not include costs for adult criminal court and detention, drug and alcohol abuse and related treatment, or potential welfare dependency (Child Abuse, 1990).

In 1974, Public Law 93-247, the Child Abuse Prevention and Treatment Act, was passed. This federal law required all states to establish reporting guidelines and laws related to child abuse. Definitions of child abuse may vary from state to state, but the majority of state definitions address physical abuse, sexual abuse, emotional abuse, and neglect.

Federal law defines child abuse as:

Physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances that indicate that a child's health or welfare is harmed or threatened.

In April of 1988 Public Law 100-294, the Child Abuse Prevention, Adoption and Family Services Act, amended Public Law 93-247. This amendment includes the recognition that children with disabilities need additional protection, and care-providers of children with disabilities need additional training.

Definitions of Child Maltreatment*

*** For your state's interpretation of Federal law, consult the Department of Human or Social Services in your state.**

Physical Abuse

- Any physical injury or pattern of injuries inflicted or caused by an adult, parent, parent-guardian, and/or caregiver
- Indicators are particularly telling if they are:
  - Repeated and consistent over time (i.e., establish a pattern)
  - Long-lasting (i.e., as one injury heals, a newer injury appears, or is discovered in a more recent state of healing)

Emotional Abuse and Neglect

- A pattern of behavior that takes place over an extended period of time, characterized by intimidating, belittling, and otherwise damaging interaction that affects a child's healthy emotional development
- Characteristics:
  - Consistent emotional abuse or neglect has the most long-term impact and may be irreversible.
  - Emotional abuse or neglect is very difficult to categorize and measure.
  - Emotional abuse or neglect is the most difficult abuse to define because of its insidious nature.
  - Prolonged emotional abuse or neglect contributes to and reinforces poor self-esteem in children and plants seeds for poor parenting in the next generation.

Sexual Abuse

- Exploitation of a child for the sexual gratification of an adult or person older than the child
- Characteristics:
  - Any act designed by a perpetrator for her/his own sexual gratification
  - Sexual intercourse need not take place and is rare in prepubertal children
  - Use of coercion, deceit, and manipulation to achieve power over child
  - The issue is misuse of power: children cannot give consent for sexual activity
  - Occurs usually in isolation, with no witnesses in order to avoid detection

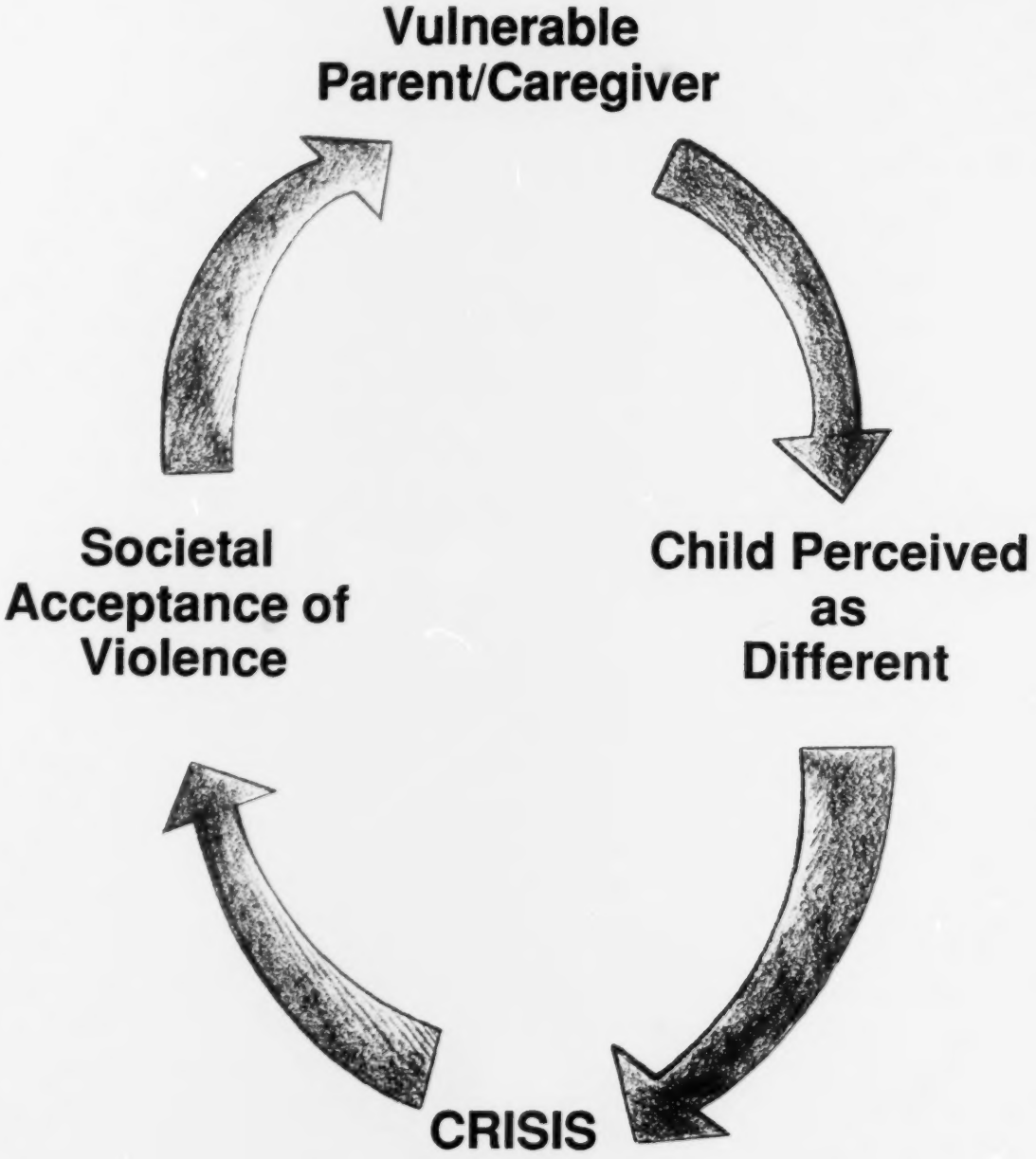
- Examples of sexual abuse:
  - Fondling
  - Exhibitionism
  - Use of children in pornography
  - Sexually provocative language and/or behavior with a child or adolescent used with the intent of coercion
  - Oral, anal, or vaginal fondling or penetration by any part of the body or by any object

Neglect

- A pervasive situation where person(s) responsible for a child's care fail to provide necessary food, shelter, medical care, supervision, or education to a child under age 18
- An absence of the love, security, and stimulation necessary for attachment and development to occur; the absence of a consistent and emotionally available caregiver
- Characteristics:
  - Parents or caregivers are uninvolved in the child's day-to-day development at any level.
  - Child's physical, mental, and emotional growth is significantly arrested with no organic cause present.
  - Neglect of children may be found in cases of physical, sexual, or emotional abuse.

* Some states have added "an injury or threatened injury" to their definitions of maltreatment. Examples of this type of maltreatment may include:
  - A parent or caregiver threatening to harm a child with a weapon or object.
  - A parent or caregiver threatening to inflict injury on the child physically or sexually.
  - A parent or caregiver threatening to abandon a child. □

ABUSE ENVIRONMENT



What Factors Increase the Risk of Maltreatment?

A common reaction when people hear about young children being abused is, "Who could do such a terrible thing to an innocent child?" The fact is that people abuse children, people just like your neighbor, your relatives, your friends. They may be good people, caring people, as well as people with many problems. Every person has the potential to become abusive. For abuse to occur, a set of circumstances that include an excess of stress and a child's presence is all that is needed.

Parents and caregivers are human beings, and each person has individual limits to how much stress each can withstand. Current documentation and research indicate that for maltreatment to occur, four elements are usually present:

- A susceptible adult caregiver
- A vulnerable child
- Significant perceived or actual stressors
- Societal tolerance for violence

Factors That Increase the Probability of Maltreatment

- Drug and alcohol use or abuse
- Abuse of spouse, significant other, or animals in the home
- Financial or emotional stress
- Socially isolated families (no external support, i.e., grandparents, relatives, friends)
- Absence or loss of significant other
- One or both parents believe in corporal punishment
- Parent(s) withholds love as a punishment
- Parent(s) receives no relief from the care of children
- Parental expectations inconsistent with the stage of growth and development the child is experiencing
- One or both parents emotionally immature
- Parent(s) abused as a child or exposed to aggressive or abusive child-rearing practices

Caring for a Special Child

Indicators of increased stress

A number of factors may increase the risk of maltreatment of a child with disabilities. If a parent or caregiver does not have adequate internal or external resources to deal with the stress associated with caring for a child with a disability, child maltreatment may occur. Ninety-eight percent of children with disabilities who have been reported as abused have known their abuser as a trusted adult (Scanlan, 1990). The following indicators and conditions may cause stress.

Why does caring for a child with a disability increase stress?

- Results in increased daily care and financial obligations to care for the child
- Support systems may be inadequate among the community, extended family, and friends
- Feelings of frustration, anger, hopelessness, guilt, shame, sadness, and worry may decrease the strength of the parent or caregiver
- Parent or caregiver may not have adequate information regarding the disability, or how it may be best managed, which can result in unrealistic expectations or slower than expected progress
- Child may have chronic or periodic medical needs requiring a great deal of care.
- Parent or caregiver may experience time and energy restraints for themselves and others in the family without any indication that these issues can be alleviated
- Resources may not be available in general geographic area and/or not adequately coordinated

A child born during a time of crisis may:

- Remind the parent or caregiver of a loss or a failure, for example: the death of a family member or close friend; divorce or separation; or loss of a job, freedom, or self-concept.
- Be a reminder of a difficult time.
- Be the result of an unwanted or difficult pregnancy.

Working with Culturally Diverse Families

Caregivers need to be aware that everyone has a different value system and each person has been exposed to different cultural child-rearing practices. Most needs of children can be generally agreed upon, yet there may be discrepancies when considering community value systems. Different cultural communities may hold beliefs that seem harsh or unnatural to someone from outside the community.

To successfully intervene, it is essential to know, understand well, and respect the cultural norms of a community, including their family system, religious beliefs, and cultural values. It is also often wise to seek the understanding, support, and help of other community members or community leaders, since they will be able to understand more clearly how a behavior may be abusive in terms of their own culture.

Members and leaders of a minority community should be directly involved in planning and implementing any prevention programs in their community. If members of a community do not

speak English as their native language, materials should be provided in their native language. If English is not the first language spoken in their homes, materials for children should be provided in the native language as well.

Child-care providers and other early childhood professionals may wish to provide inservice training for their staffs in regard to cultural sensitivity and cultural competence.

Resources for working with culturally diverse children and their families are included in the Additional Resources starting on page 95 and also in the References to other chapters in this handbook.

The transition to parenthood has an impact on ALL families.

Breaking the Cycle of Abuse

All infants, toddlers and preschoolers have certain needs. Children with disabilities, however, may have special needs that require more time and effort, as well as adding to family expenses, therefore increasing family stress. Yet all children need physical care, nurturance, time, and physical and emotional space to grow. It is the adult's responsibility to meet the child's needs; a child cannot meet an adult's needs. Adults need to take responsibility for finding help or assistance to meet their own needs.

Needs of caregivers

In research results from the Mother-Child Interaction Project and Project STEEP, conducted by Byron Egeland, Martha Farrell Erickson, and Alan Sroufe of the Child Development Center at the University of Minnesota, three factors that most influence breaking the cycle of abuse are discussed:

- **Nurturance and support** during childhood from some adult other than the abuser
- **A supportive relationship** with a current partner
- **Involvement in therapy** for at least six months

A child born during a time of crisis

- May remind the parent or caregiver of loss or failure – for example, a death in the family or of a close friend; loss of a job, or of freedom or self-concept
- Is a reminder of a difficult time
- May have been an unwanted or difficult pregnancy

When caregivers have experienced maltreatment in their own childhoods, they may have missed developmental steps or areas necessary to parent their own children. One of these areas is the ability to learn play skills.

Adults who did not learn to play as children may have difficulty:

- Relaxing.
- Putting aside work to take care of themselves.
- Being flexible.
- Understanding the importance of play for their own children.
- Understanding the benefits play can provide in interfamily relationships.

In some cases when parents were themselves abused as children, their own maltreatment may or may not have been reported, and if reported, the child protection system could not or did not respond. In these instances the caregivers, now, may not validate their own abuse, or they may have developed the coping and survival skills necessary to stay in their abusive family systems, which are recognized as "dysfunctional," that is, unhealthy or uneven family systems.

For example, when children who have been abused remain in abusive homes or systems, they may develop dissociative episodes to allow them to remain in their families. (To dissociate is to separate. Maltreated children often deal with or cope with their pain by splitting themselves off from the painful reality of abuse and blocking it out of their consciousness.) This pattern of dissociation often continues into adulthood and not only allows them to avoid any experiences associated with hurt and pain, but also can prevent them from developing healthy, nurturing, and caring relationships with their own and other children and with other adults.

How caregivers currently perceive their own childhood experiences has an impact upon their relationships with their children. When intervention does not occur to allow caregivers to integrate their own childhood experiences, they may idealize those experiences, view them as all good, or be flooded by negative feelings.

Caregivers who get caught up with their own childhood experiences may have great difficulty being sensitive to their children's needs. For example, caregivers who have not worked through their own victimization may misinterpret their children's cries. They may believe their children's cries are a way to annoy them or get even, instead of realizing they are a signal that something is not right with the child.

New ways of experiencing a full range of emotions and of interacting with others need to be learned by families to break the cycle of abuse. Prevention efforts that empower caregivers to evaluate their own experiences as children correctly and provide for resolution of those experiences free caregivers to attend to their own children's needs. □

Common Characteristics of Abusive Caregivers

Physical Abuse	Sexual Abuse	Emotional Abuse and Neglect	Physical Neglect
Caregiver's Characteristics	**Caregiver's Characteristics**	**Caregiver's Characteristics**	**Caregiver's Characteristics**
Conceals the child's injury Does not seem worried about the child Describes child as bad, different, selfish Believes in severe discipline Unrealistic expectations Low self-esteem Abuses alcohol or drugs Markedly immature Maltreated as a child Projects blame on others	Possessive and jealous of the child History of sexual abuse in childhood Abuses alcohol or drugs Socially isolated Poor relationship with spouse Immature, childlike impulse control Perceives that child enjoys sexual relationship Perceives sexual relationship of parent and child to be indicators of love and affection	Unrealistic expectations of child Threatens child Name calling or belittling Treats siblings unequally Low self-esteem Seems unconcerned about child Withholds love as punishment	Apathetic or passive Depressed Socially isolated Low self-esteem Unsafe living conditions

References – Child Maltreatment: Definition and Risk Factors

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Children's Development

and

Indicators for Maltreatment

An infant's world is like a stage, a stage upon which life's outcomes are determined . . .

Infants: Birth to Eighteen Months

Development

Each infant is born with an individual and unique temperament, as well as inherited physical characteristics. Many emotional, physical, and environmental influences, however, have an impact on a child's development in this crucial stage of life. When the processes of development are altered by chronic illness, disability or maltreatment, an infant is at risk.

In the first year of life the brain doubles its size and every month a new neurological system is introduced. Other forms of physical development are dramatic during this time as well. Infants learn to turn from side to side, sit up, crawl, and sometimes to walk. (More information about physical development can be obtained from a physician, public health department or nursing service. Some of the books in the References at the end of this section and in the Additional Resources beginning on page 95 also have information about child development.)

During the first year of life, infants also learn how to trust the world by their interactions and emotional attachments with their caregivers. It is during this time that infant and caregiver learn to read each other's cues. Parental interactions and behaviors are critically important, since they have an impact on a child's mental health and establish the groundwork for later psychological development. The abilities to trust, communicate feelings, learn right from wrong, develop a conscience, and respond appropriately to life are all fostered during these first 18 months of life.

Caregivers are the designers of their child's experiences in these first important months of life. Without adequate skills and resources this task may become overwhelming, making it difficult to establish healthy boundaries between themselves and their child. And caregivers who do not have the adequate internal or external resources to meet their child's emotional and physical needs during these crucial months of development may become vulnerable to possible abusive behaviors.

Attachment and trust, and their importance to healthy emotional development, are discussed in the following pages. The development of infant sexuality is also clarified. In addition, several types of infant abuse and maltreatment, and ways to prevent them, are defined and described.

Bonding, attachment and trust

During the first 12 to 18 months of an infant's life, a child develops her or his own sense of trust. Primary caregivers' relationships with an infant are crucial in the establishment of trust. It is through this relationship that an infant learns to trust that others will care for her or him and to feel worthy of that care.

Bonding is the interaction that takes place between primary caregivers and a child immediately after birth. An infant is born with certain behaviors that provide opportunities for interaction with caregivers: examples include sucking, cooing, crying, etc. If an infant's signals do not result in interaction with their caregivers, bonding, and therefore attachment, cannot develop fully.

Attachment is a process that takes place over a period of time and is not completed until after the infant recognizes that caregivers are present, even when they cannot be seen. Attachment is observed when an infant seeks closeness with a caregiver and uses the caregiver as a base from which to explore surroundings.

The amount of sensitive, responsive care the infant receives during the first 12 months determines the quality of attachment. There are different degrees of attachment, depending upon the sensitivity of the caregiver's interaction with the child. These different degrees determine a child's attitudes and expectations of him- or herself and others. (For more information about different degrees of attachment, see Erickson & Egeland, 1987.)

Emotional development and abuse prevention

A great deal of research and evidence has been offered about the long-term impact on children of overt sexual and/or physical abuse or blatant physical neglect. Far less information is available about how more subtle forms of emotional maltreatment and/or emotional neglect affect children.

The Mother-Child Project, a longitudinal study at the University of Minnesota, has offered evidence that illustrates the long-term outcome for infants whose caregivers are "psychologically unavailable," that is, when a caregiver is emotionally unresponsive to a child. This project has demonstrated the effects on infants when they cannot establish security and trust in the first months of their lives.

A caregiver who cannot sensitively respond or be emotionally available to an infant will have an impact on that child's development. Examples of effects on the child include learning problems, poor psychosocial functioning, lowered self-concept, and a fear of failure. The prevention strategy is for caregivers to learn, practice, and participate in new ways to parent and interact with their infant.

Goals for families to help resolve issues of abuse and neglect

Project STEEP, a preventive interaction program based on the findings of the Mother-Child Project, has identified goals for families that will help increase the likelihood of secure attachments and help resolve issues about abuse and neglect in the caregiver's childhood in order to prevent their repeating what they themselves have experienced.

Infants

Birth to 18 Months

During this period, an infant

- Brain doubles in size
- Develops a new neurological system every month
- Learns how to trust
- Needs to reach a relaxed alertness by himself/herself
- Forms attachments and bonds with caregivers
- Develops a basis on which he or she will accept/reject the world

These prevention goals for families are:

- To promote healthy, realistic attitudes toward pregnancy, childbirth, and childbearing.
- To help parents/caregivers understand child development and form realistic expectations based on that knowledge and understanding.
- To help parents/caregivers respond sensitively to the child's cues and signals.
- To help parents/caregivers develop perspective, particularly in regard to the child.
- To help parents/caregivers create a home environment that is conducive to the child's healthy, competent development.
- To help parents/caregivers strengthen support networks that can facilitate effective parenting and help them build self-confidence.
- To help parents/caregivers develop life-management skills that can minimize stressful events and help them build a solid life for self and family.
- To help parents/caregivers see options and feel powerful enough to pursue them (breaking the "yes, but . . ." game).
- To help parents/caregivers examine their own history of care, their feelings about that care, and the way their history influences the way they care for their child.

> ***The integration of the body, mind, and spirit of the human being is the basis of sexual health.***
>
> ***—World Health Organization***

Development of sexuality in infants

The development of sexuality is one of the least discussed topics in developmental literature. It is, however, crucial to an individual's healthy self-image that the development of sexuality be understood and its importance recognized.

While infant sexual differences are just beginning to be understood, certain patterns in the development of sexuality in infants have emerged.

One phase of development is the satisfaction an infant feels when he or she sucks, is held, touched, rocked, and cradled. As an infant grows, this stage may extend to an infant's recognition of a favorite toy or blanket. As a part of infant development, infants may touch their genitals as they explore all parts of their bodies. Response to this normal exploration needs to be thoughtful, caring, and understanding.

Another normal phase in the development of an infant's sexuality is genital play. Just as infants play with their feet, they may play with their genitals. An infant also may self-stimulate by rubbing a blanket or toy when trying to get to sleep.

What is important is not to punish an infant for any of this normal behavior, such as exploration of the body, genital play, or self-stimulation. Punishment may result in increasing the behavior. Generally, over time, the behavior will diminish.

The final phase of development is the infant's identification of gender role. Gender roles are passed on to infants by their conditioning, rather than being only a function of the child's biological sex. For example, little girls are often cuddled and shown much tenderness, while little boys are talked to in a manner that prompts action or engaged in more rigorous play activities, such as bouncing.

Cultural characteristics and values greatly influence the manner in which all young children, including infants, are treated and conditioned to gender roles. In caring for infants from a different culture, an awareness of family cultural patterns is helpful in understanding the child's responses.

Risk for parents or caregivers who have been sexually abused

A parent or caregiver who has been sexually abused may not be able to set clear limits around physical boundaries, which makes the parent or caregiver more vulnerable to abusive behavior. The sexually abused caregiver may be confused about the infant's sexual development or feel uncomfortable about the infant's behaviors. He or she also may be overprotective of infants, especially girls, in their normal exploration of themselves and their environments. The caregiver may need to examine her or his own beliefs and views and may need to relearn information regarding sexual development and physical boundaries.

Preterm and Premature Infants

Parents of a premature infant or an infant born with a disability or chronic illness may go through the same grieving process as people do when someone in their family dies. Elizabeth Kubler-Ross in her book, *On Death and Dying*, identifies these stages as:

- Shock/denial
- Anger
- Bargaining
- Despair
- Acceptance

Parents of premature infants may move through these stages rapidly, may not go through all five stages, or may take a long time to reach the stage of acceptance. It is very important these families receive the support and resources necessary to gain an acceptance of their child. The degrees of acceptance are as individual as each infant.

Frodi and Lamb (1980) list several reasons why a preterm or premature infant may be at an increased risk:

- The child's physical characteristics may often be different from what the caregivers expected. The infants may be small, may seem unattractive, and may require very special care.
- The infant's cries are often irregular, high-pitched, and weak. Their cries can trigger the part of the caregiver's nervous system that governs involuntary actions (the autonomic nervous system), such as anger and aggression.
- Because the crying may be uncontrolled at times and regular soothing efforts may be ineffective, the caregiver may feel the infant does not like her or him. If the caregiver cannot comfort the infant, he or she may feel frustrated and inadequate. The caregiver also may have unrealistic expectations of the infant and may need to develop additional skills in order to meet the infant's special needs.
- Sleep patterns may be disrupted, and the caregiver may not be able to get enough rest to interact effectively or sustain the necessary techniques to provide physical care for the infant.
- Muscle tone can be affected by neurological complications, which may produce muscles that are either flaccid or spastic. These complications may make the infant difficult to hold and position, and the infant may be unable to reach a relaxed state. The infant also may be chronically restless as well as hypersensitive to stimuli, even to parental handling.
- The infant may be unable to connect emotionally with the parents or other caregivers by cooing, smiling, or eye contact, which might be interpreted as rejection.
- The infant may have difficulty feeding when unable to suck correctly.
- Lengthy and frequent hospitalization may interrupt the bonding process for the caregiver and infant. In infancy the child and parent learn about each other; separation can affect the caregiver's ability to be sensitive in identifying the child's distress signals, and he or she may not be as effective in coping with irritable behaviors, such as constant crying. The child in turn may have a diminished ability to respond to the caregiver's comforting efforts.
- The preterm or premature infant can also have a difficult time adjusting to new routines or may exhibit negative responses or behaviors when new stimuli are introduced.

Infant Maltreatment

Infants with colic

Colic is characterized by intermittent, unexplained bouts of crying, which can last anywhere from a few minutes to several hours. No one knows exactly why some infants have colic and others do not. Colic in and of itself is not an indicator of maltreatment. In cases where infants have died as a result of maltreatment, however, colic is a common factor.

Colicky behavior may begin as early as the first month after birth. Crying may or may not occur at regular times during the day or night. The infant may scream, pull her or his legs up toward the face, and generally be in distress. An infant is extremely difficult to comfort during these times, and it is essential that the caregiver have the resources and coping skills to comfort the infant and be able to take care of herself or himself at the same time.

Parents and caregivers need to know it is all right to seek relief from a crying infant by leaving the room for a brief period of time. For longer periods, parents or caregivers may obtain respite help from an agency, friend, or relative.

Shaken Infant Syndrome (SIS)

Shaken Infant Syndrome is one of the most preventable types of infant and young child abuse. It is preventable by *NEVER SHAKING* an infant or young child and by always providing gentle support for an infant's head, as well as by educating others to provide that additional support.

The victims of SIS are usually under the age of 2, with the most susceptible children being between 3 and 24 months of age. More than 90 percent of the infants examined for possible SIS showed bleeding of the brain (Mullen, January, 1990). With the use of improved medical technology over the past few years, such as the CAT (Computerized Axial Tomography) and MRI (Magnetic Resonous Imagery) scans, trauma to the brain is now more easily detected.

For SIS to occur, there must be a considerable amount of force exerted upon the infant. The amount of force that causes severe damage can happen in just seconds. The person who shakes the infant is commonly feeling anger and extreme frustration. Often the frustration occurs when an infant will not stop crying. Even though the caregiver has made every reasonable attempt to quiet an infant, the infant may continue to cry. The caretaker may pick up the baby and then shake the baby to "just make it stop crying."

The amount of force exerted on the infant when being shaken may be compared to spiking a ball or shaking a can of paint. An infant with not fully developed, weak neck muscles will suffer severe whiplash. Because the skull is soft, and there is still room for the brain to move about, severe damage to the brain also occurs. The types of injuries that can result from shaking an infant range from permanent brain damage, to blindness, seizures, and delayed motor and sensory development or combinations of developmental delays.

Nonorganic Failure to Thrive (Failure-to-Thrive Syndrome)

Among the different forms of infant/child neglect, "failure to thrive due to parental deprivation" is the most obvious. Brain damage can and does occur from severe malnutrition during the first year of life.

A child suffering from the failure-to-thrive syndrome is one who at some time during the first three years of life suffers a noticeable retardation or cessation of growth, which is usually evident in weight, height, and head-circumference abnormalities. All bodies are fine-tuned instruments, and when a child does not yet talk (is preverbal), her or his body may respond directly to deprivation or maltreatment in an effort to receive intervention.

Infants with failure-to-thrive syndrome may physically appear weak, pale, and listless, have decreased muscle tone, and be inactive physically. Failure-to-thrive syndrome may be found in combination with physical and/or emotional maltreatment.

Possible indicators of maltreatment and neglect in infants

When a list of indicators is used in assessing maltreatment, the best guide is knowing what is normal for each infant. This knowledge is essential when working with children who have disabilities.

- Physical indicators of maltreatment:
  - Breathing difficulties
  - Physical bruises or marks
  - Unusual vomiting, especially if it contains blood
  - Blood in diapers
  - Bruises, marks, or lesions around the genital areas or by the mouth.
  - Contact or immersion burns
  - Bulging or recession of the soft part of the scalp commonly known as the "soft spot"

Note: Immediate medical attention may be required if any of the preceding signs are observed. All of the above indicators may have other serious medical causes as well.

- Other possible indicators of maltreatment:
  - A sudden or dramatic change in alertness or attentiveness
  - Extreme agitation toward self or others, places or objects
  - Less or very little cooing or attempts at language
  - Less or little smiling, eye contact, or exploring
  - Inappropriate dressing of an infant, which could be covering physical evidence

Note: The preceding set of possible indicators may be related to disability in some children. □

Toddlers

18 Months through 2 Years

Toddlers create their own sense of self through caregiver's PRAISE

Toddlers: Eighteen Months through Two Years

Development

Toddlers are in the process of continuing to develop a sense of self. Most toddlers' actions and emerging words are centered on themselves as they explore their world and try to become more independent. At the same time, separation from their caregivers can bring about tantrum-like behavior, since they have not gained the social skills that will allow for many new people to be accepted into their lives. Their caregivers are primary in shaping their lives and responses. When maltreatment occurs during this developmental period, the results can be tragic.

At this age thinking abilities surface, and toddlers have more ability than infants to manipulate their surroundings. Memory is more formed: a central image can be maintained for longer periods of time. Abstract thinking is starting to form and linguistically they learn more each day. Their individuality, imagination, creativity, and problem-solving abilities are emerging.

This stage of development is also when children learn to experience success, the feeling they can do things for themselves, and a sense of independence, which increases self-esteem. The world can be very large and intriguing at this age. Curiosity is at its peak. Toddlers want to do what others do, even when they lack the skills. Their curiosity and assertiveness can cause conflict with a parent or caregiver as toddlers explore their surroundings and learn what acceptable behavior is while defining their sense of self.

How to view a toddler's world

It is very important for caregivers to have empathy with and an understanding of their toddler's world. One way to practice a toddler's viewpoint is to get down to about 36 inches from the floor, which for many is on your knees. Look around your environment and experience what is at eye level. Often it is the coffee table with a family heirloom that is very appealing, or the color knob on the television. Getting on their level from time to time helps us better understand their temptations, frustrations, and sense of being so small.

Children at this stage need praise—their own sense of self will be rewarded only with praise. Toddlers who get sufficient direction and consistent limit-setting combined with nurturance learn healthy guilt, which allows them to make good choices as they grow and develop. (Guilt is the result of knowing one's behaviors create a consequence; learning about guilt is a part of everyone's normal development.) However, when a child believes he or she is bad, shame develops. Shame can cripple the rest of a child's development. It is very important toddlers hear the message, "Your *behavior* is not okay, but *you* are."

The security of a healthy emotional attachment, as discussed in the previous chapter, also plays a pivotal role in toddlers' development and is crucial in fostering independence and self-esteem. Toddlers whose needs are not met with responsiveness and sensitivity may exhibit many desperate behaviors, such as intense power struggles. Their negativism (as they learn to use the word "no") is a way of defining self for them and needs to be responded to with questions, such as "What do you need?" The task of caregivers is to find a balance between protecting

toddlers from their own impulses and encouraging their sense of self by providing affection and support, while at the same time respecting independence and autonomy.

> ***From a sense of self-control without loss of self-esteem, comes a lasting sense of good will and pride; from a sense of loss of self-control and of foreign over-control, comes a lasting sense of doubt and shame.***
>
> ***—E. Erikson, 1963 (cited in Erickson & Egeland, 1987)***

Development of sexuality in toddlers

Characteristics of normal development in toddlers:

- Kissing and hugging people who are important and feel safe to them
- Becoming more aware of their genitals and curious about the feelings experienced when their genitals are handled
- Beginning to have an awareness of the genital differences between females and males
- Beginning to become curious about the genitals of others

Characteristics of Children with Disabilities

Children with chronic illness or disabilities may begin at this developmental stage to notice that they are different and require things that are different from those around them. It is critical to be able to identify their strengths and capabilities for them to feel a sense of self-worth and build on those principles.

Conditions that increase stress for parents and caregivers

A child with emotional/behavioral disorder, attention deficit disorder, hyperactivity, and other related learning disabilities may:

- Experience difficulties in learning that parents do not understand.
- Require highly structured and consistent limit-setting in order for the child to be successful.
- Demand much time and effort, which results in parent or caregiver having less energy and may contribute to stressful and wearing relationships between parent and child.

A child with autism/language disorders may:

- Be unable to communicate or have limited communication abilities.
- Engage in acting out behaviors.
- Be withdrawn.
- Have limited responses.

A child with physical or sensory disabilities (blindness, deafness, cerebral palsy, muscular dystrophy, etc.) may:

- Be physically dependent on family members.
- Need special or adaptive equipment for daily living, some of which is difficult to obtain and may or may not be covered by insurance.
- Need more resources and special handling.

A child with mental retardation may:

- Have greater dependency needs.
- Be slower in visible progress.
- Achieve developmental levels at a slower rate and in different ways.
- Be affected by real or perceived social attitudes or stereotypes.

Maltreatment of Toddlers

As with infants, the significant factor in identifying maltreatment in toddlers is identifying the norm for each individual child. For example, some children are naturally aggressive; their aggressiveness does not mean they have been mistreated. Children with physical limitations may have great difficulties with balance; every bruise is not evidence of maltreatment. One thing to keep in mind with observation is: Does the explanation given for the injury fit the injury being observed?

Children need to be allowed to grow with the utmost respect for their feelings and needs to lessen the risk of their own temptation to hurt others or themselves. Children who are maltreated physically, emotionally, or sexually learn to repress feelings of hurt and pain, which uses energy that should be directed toward exploring their world and learning about life.

Maltreated children appear to go through the motions of living, but quite often are unable to experience real joy. Suffering at this stage can stifle imagination and creativity. Maltreated children do not feel enough trust to seek out anyone to comfort them, a distrust that often continues into adulthood.

Toddlers constantly watch those around them and their actions. If corporal punishment is used for discipline, they learn: "When I get frustrated, angry, hurt, or scared, it is okay to hurt someone else."

Toilet training

Toddlers become fascinated with the idea of the "bathroom" and with bathroom language. This fascination is normal, and they will move on as they increase their vocabulary.

A child is ready to be toilet trained when he or she has:

- Reached the age of 2 to 3 years.
- Achieved coordination and has some muscle control.
- The ability to follow some verbal instructions.
- The ability to relate that he or she needs to go to the bathroom.
- A bladder and bowel mature enough to hold the urine and stool for lengths of time.
- A willingness to want to learn to use a training chair.

Some guides for parents:

- Select which words to use and stick with them.
- Establish toileting as a routine.
- Support the child and praise her or his efforts, even when accidents occur.
- Know that accidents will happen, and punitive words and actions around toilet training may result in frustration and a heightened sense of will, and therefore may take more time to produce the desired results.
- For parents of children with disabilities, toilet training can be a frustrating time if they do not have correct information concerning their child. Contact a physician or a public health nurse for information and assistance. □

Child Maltreatment
of Toddlers and Preschool Children

Types & Indicators

- **Any list of physical and behavioral indicators of child abuse must be used with caution.**
- **Checklists are intended to alert professionals, parents, and caregivers to the possibility of abuse that may have occurred or may be occurring.**
- **Any combination of symptoms may be significant and should be reported.**

Physical Abuse

Physical Indicators	***Behavioral Indicators***

• Evidence of repeated injuries in various stages of healing and/or in clusters
• Patterns of injuries do not coincide with description of how it happened
• Unexplained bruises and welts
• Unexplained burns
• Restraint injuries commonly appear:
  • Around the mouth
  • Around the neck or mid-section
  • Around the feet or hands
• Head trauma
• Eye injuries
• Facial bruises and lacerations
• Areas of missing hair
• Indications of bite or teeth marks
	• Sudden or pronounced new fears
	• Nightmares or night terrors
	• Behavior extremes
	  • Passive
	  • Aggressive
	• Easily frightened
	• Wary of physical contact
	• Poor social relations
	• Fear of going home
	• Destructive to self or others
	• Child appears to fear any disciplinary action
	• Excessive crying when scolded
	• May appear jealous of attention paid to other children
	• Child reports abuse

Emotional Abuse

Physical Indicators	Behavioral Indicators

• Physical problems exacerbated by emotional distress:
  • Stuttering
  • Asthma
  • Ulcers
  • Allergies
  • Recurrent bedwetting
• Regressive behaviors that are sudden or pronounced
• Non-organic failure to thrive
• Low self-esteem
	• Overly passive or compliant
	• Aggressive or demanding
	• Overly adaptive behavior
	• Inappropriately mature
	• Developmental lags not associated with a disability
	• Sleep disorders
	• Conduct disorders
	• Depression
	• Child perceives self as worthless
	• Phobias, new fears

Sexual Abuse

Physical Indicators	Behavioral Indicators
• Regression in toilet habits • Torn, stained, or bloody underclothing • Difficulty walking or sitting due to injury • Bloody or purulent discharge from genital or anal areas • Loss of appetite • Unexplained gagging	• Excessive clinging behavior • Excessive masturbation • Lots of new fears • Poor self-image • Bigger, sophisticated, or unusual sexual behavior or knowledge • Sudden onset of behavioral problems • Avoidance of bathrooms or other areas of a house • New and pronounced fear of sleeping alone • Nightmares and night terrors • Child reports abuse

Physical and Emotional Neglect

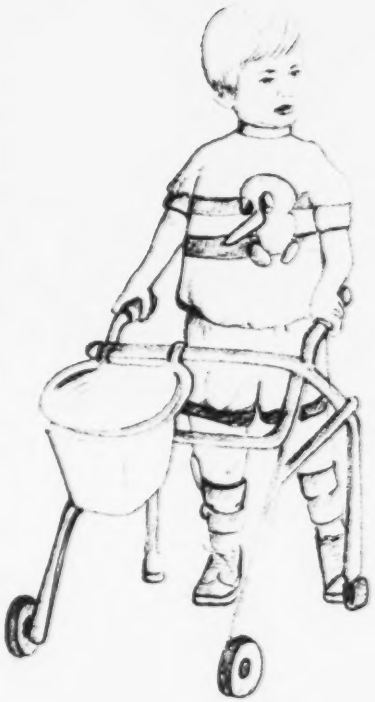
Physical Indicators	Behavioral Indicators

• Lacks adequate food
• Poor hygiene
• Lacks appropriate clothing
• Unattended physical problems:
  • Medical
  • Dental
• Constant fatigue or listlessness
• Feelings of or actual abandonment
	• Failure to thrive in general, frail
	• Extremes in behavior
	• Depressed, dull, apathetic in appearance
	• Problems associated with food
	• Excessive:
	  • Begging
	  • Stealing
	  • Refusal to eat
	• Development lags not associated with disability
	  • Physical
	  • Emotional
	  • Intellectual
	• Feels unwanted, describes self negatively
	• Exaggerated fear of adults

Preschoolers: Three through Five Years

Development

Three-year-olds



Three-year-olds continue to develop in their play and independence. At times they can demonstrate the abilities of four- and five-year-olds, but easily revert back to toddler behaviors, especially when in new opportunities and situations. Three-year-olds have the ability to play with peers; however they prefer independent activities or activities with their caregivers' direction and participation. The three-year-old's physical skills become more defined, and they require uninterrupted time to practice their skills.

These children have a curious nature and want to learn about their environment. A three-year-old can usually understand simple and consistent directions, but may be unable to remember them for any length of time. With still limited cognitive development, they may attempt activities that are not safe or are beyond their developmental capabilities. Their language capability expands, and they rapidly increase their vocabulary. They often ask about their surroundings.

Four- and five-year-olds

When a child moves beyond the third year of life, the ability to form social contacts and participation in group activities increase. Four- and five-year-olds learn from both positive and negative interactions and often will mimic behaviors with some regularity.

Four- and five-year-olds have more concrete ability to learn and have many questions about the things around them. They are better prepared to understand the concept of consequences, have more ability for self-control, and demonstrate conflict-resolution skills. These children learn through participatory activities, observation, and direct interaction with others. Four and five-year-olds begin to recognize the differences of gender and are vulnerable to acquiring prejudices and stereotypes.

Development of sexuality in three-, four-, and five-year-olds

Characteristics of normal development in three- and four-year-olds:

- Identification of sensations during genital play becomes more defined
- Fascination with bathroom matters
- Development and usage of bathroom language is funny to the child, but may be embarrassing for an adult
- Curiosity about sex and such questions as, "Where do babies come from?"

- A need for increased privacy, especially around excretion
- Touching of genitals and the need to urinate when stressed or excited

Characteristics of normal development in five-year-olds:

- Decreases open genital display as becomes more modest
- More serious and better at imitating adult behavior
- Understands where babies come from
- Very aware of physiological sex differences
- Play includes games with peers, such as doctor, family, marriage, etc., with gender roles assigned according to sex (boys are fathers, girls are mothers, etc.)
- Increased ability to feel for others and beginnings of conscience and moral reasoning

Four- and Five-Year-Olds with Disabilities

Verbal children at this stage of development who have disabilities begin to ask questions regarding their differences, which can be a very difficult process for their caregivers. The messages of guilt and questioning of themselves can be overwhelming for the caregivers when they do not have adequate support to answer the questions their children pose.

Children with learning disabilities may become keenly aware that other children appear to have less difficulty learning new activities. The child's own frustration level and anger control may be seriously challenged. Their lack of impulse control combined with short attention spans can be taxing to a caregiver who does not understand their special needs and who has not acquired specialized techniques to assist the child. Caregivers need to be encouraged to seek support and help to learn skills to help their child and themselves.

Note: The indicators of child maltreatment for preschoolers are the same as for toddlers. (See the previous chapter about toddlers.)

Sexual Abuse of Children Three through Five Years

Sexual abuse is more about power and control than it is about the sexual act. Abusers may seize power and control through sexual acts in attempts to: raise their self-concept, bolster their own ego strength, or engage in a form of intimacy they are unable to achieve within their own peer group.

According to current statistics, one in four girls and one in six boys may be sexually abused before age 18. Perpetrators of sexual abuse can be male or female (Bass & Davis, 1988).

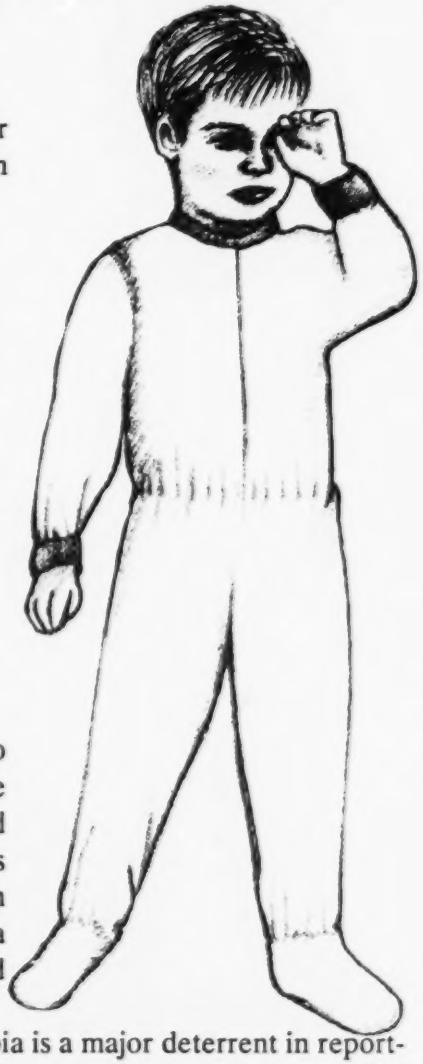
Young children do not have the knowledge to act out sexually unless they have witnessed or experienced this type of activity. Often children who have been sexually abused act out their abuse with other children, use sexually explicit language, or express their pain through drawings, paintings, or with their toys.

Generally, boys tend to act outwardly when sexually maltreated, and may themselves become abusive or aggressive; girls are more likely to internalize and discount their pain by acting depressed and quiet. (Boys, however, may become withdrawn and girls act out) (Bear & Dimock, 1988). Whatever the reactions, the effects of sexual abuse are traumatizing.

Children with disabilities

Children with disabilities are at an increased risk for sexual maltreatment when they lack the ability to communicate what has happened to them. Children with hearing impairments need to know how to sign the names of the body parts. If inappropriate sexual activity does occur, they will be considered more credible witnesses if they know the terms for the critical body parts.

All children with disabilities need to know how to correctly name their gender-specific body parts.



Abuse of male children

The victimization of male children has been overlooked or underreported until just recently. The reason for this omission is largely based on the following societal beliefs:

- It is not "manly" to be a victim, show feelings, or be affected by abuse.
- Males should be able to protect themselves in any situation.
- Males should be able to "tough it out" rather than ask for help.
- Homophobia: We often refer to the same-sex assault as homosexual molestation, but research indicates the majority of same-sex assaults are perpetrated by heterosexuals.
- Males do not perceive sexual acts as abusive.

Women who sexually abuse children

Although research on the incidence of women who sexually act out against children is limited, studies by Diane Russell and David Finkelhor indicate that 5 percent of girls and 20 percent of boys are sexually abused by women (cited in Bass & Davis, 1988). Some clinicians believe the incidence is much higher. In more recent research reported by Walter Bera (1990), approximately 25 percent of male children reported being abused by women.

Same-sex abuse also occurs between females. Homophobia is a major deterrent in reporting same-sex abuse by women. Certain stereotypes and societal myths contribute to societal disbelief that women can be abusers, as listed by Bass and Davis in *The Courage to Heal*:

- Women aren't sexual.
- Women are gentle.
- Women are passive.
- How could a woman do that to a child?

Until we as a society learn more about sexual maltreatment and what questions need to be asked, the actual incidence of women as abusers, including abuse of sons or daughters by mothers, cannot be determined. Until that time, children will continue to suffer, since breaking the cycle of silence is necessary to begin the healing process. □

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Reporting

Reporting

Reporting of Child Maltreatment

Reporting

Reporting

Reporting

Empower:

To give legal power or official authority to; authorize

—American Heritage Dictionary

How to Talk to a Young Child When Abuse is Suspected

In the following guidelines sexual abuse is emphasized, since it is the most difficult kind of abuse to talk to a child about, with the possible exception of some kinds of emotional abuse, and the type of abuse most likely to be kept "secret." All too often the societal or cultural taboo is not the act of sexual abuse or incest itself, but talking about it. These guidelines, however, apply generally for all types of abuse.

Impact of Sexual Abuse

The degree of traumatization from sexual abuse depends on certain factors that can influence the traumatic impact for a child.

The following factors are significant:

- Age and developmental stage of the child
- Closeness and type of relationship between offender and victim
- Intensity, duration, frequency, and nature of the abuse
- Prior emotional stability of the child and family
- When, where, and if the abuse is disclosed
- Support of the child by family members and the community during and after disclosure
- Procedures used in investigation and interviews
- Possible removal of the child from home
- Handling of court procedures
- Media handling of news reporting

Reasons Why Children Do Not Disclose Abuse/Incest

The following are some reasons why children do not tell about their abuse experiences:

- Victim's feelings of shame and guilt toward mother and/or father and family
- Fear of men; lack of trust: Who will believe them?
- Passive behavior, low self-esteem, feeling that he or she will be branded
- Lack of awareness that this form of sexual activity is inappropriate
- Fear of being removed from home
- Fear of being responsible for break-up of family
- Fear of losing family

- Alienation from rest of family; may be rejected if they tell someone
- Social isolation of family, socially deprived
- Dependency of victim, no ego development
- Threats to child, such as "I'll hurt you"—or offender tells child he or she will go to jail; other similar threats
- Ill-equipped to deal with outside world, immature, scared
- Fear of incest occurring with next eldest child; protective of younger child
- Confusion
- Denial and projection of blame toward the child
- Lack of understanding or empathy with the child from adults around the child
- Lack of communication or chaotic life style

The information on the Impact of Sexual Abuse and Reasons Why Children Do Not Disclose Abuse/Incest is adapted from information from Autumn Cole, Ph.D., Licensed Psychologist. Used and modified with permission .

Discussing Abuse with a Child

Five critical components are:

- **Believe her or him!**
- **Empower ...**
- **Support ...**
- **Validate ...**
- **Follow Up ...**

Believe her or him!

- Accept what the child says about what happened.
- Let the child set the pace. Use the child's terminology, but be sure to use words the child understands (especially important for children with speech and language difficulties).
- Ask open-ended questions. (Do not use leading questions that require a yes or no response such as, Did your brother touch you here?)
  - Examples of open-ended questions are: What happens when you are with that person? What happens next? Where are you when this happens?
- Remain calm if an injury is observed.
  - If the child is persistent about having the injury observed, ask another person to remain as a witness.

Empower . . .

- Empower children through education about child abuse and knowledge of reporting procedures. A child does not have the power or knowledge to resist abuse and will not understand the concept of abuse. By knowing and using reporting procedures, the person reporting is able to make use of the legal power the child does not understand that grants her or him the right not to be abused.
- Do not appear shocked or horrified by what the child has shared. A child may not seek help if they perceive they have shocked or frightened someone. They may not tell at all or may tell what they are expected to say, rather than the truth.
- Acknowledge that by telling about the abuse, the child has not done anything wrong. Help the child understand that it is not bad for her or him to talk about things that others may do to hurt the child. (Young children tend to understand things as either good or bad.)
- Maintain confidentiality. Young children do not have the cognitive ability to understand the concept of confidentiality. Do not tell a child that this information will be kept totally a secret, but do say that only people who need to be informed will be told.
- It is not the reporter's responsibility to **investigate**, or to **confront** or **question** the possible perpetrator. To do so may put the child at greater risk for harm. It is the responsibility of the trained professionals who are given the report to investigate and also to inform the child's parents.
- Sometimes young children may say the abuse happened to a friend (especially preschoolers), when it really happened to them. Telling their parents what the child described may set up a situation of risk for the child, so it is always best to let the authorities inform parents.

Support . . .

- Choose a private, non-threatening setting.
  - Engage the child with an activity. Examples are clay, drawing, etc. Activity helps the child feel less threatened while discussing the abuse. If the activity produces further indications of maltreatment, save the pictures or other materials to share with the authorities.
  - Do not use a time-out room if the child involved regularly uses it during times of misconduct, since the child may then get the idea she or he has done something wrong.
- Sit near the child, but respect her or his need *NOT* to be touched.

Validate . . .

- Reassure the child that he or she has done nothing wrong.
- Affirm her or his feelings. Be comforting.
  - Children who have limitations in perception may be very confused by what has happened and may not totally understand the abusive act.
- Use the child's terminology.
- Consider her or his developmental level or disability.
  - If necessary, seek out other personnel who would know the child's level of functioning, such as a social worker or child psychologist.

Follow Up . . .

- Write up brief notes immediately, including date and time of disclosure.
  - With a child who has a limited vocabulary because of a disability, be sure to document any unusual physical observations of the child, such as unusual body language indicative of abuse.
  - Follow reporting policies established by local police and social service agencies.
  - If the child requires special services, such as an interpreter for a child who is hearing impaired, be sure to tell the person who receives the report.
  - If English is not the native language spoken in a child's home, the child may need an interpreter.
- Let the child know she or he can expect continued support.
  - Provide ongoing reassurance to enable the child to feel positive about reporting. Helping an abused child restore confidence and belief in himself or herself is essential for the child's healing.
- Seek validation and support regarding the abuse and the disclosure of information. A support system will help assure that any anger about the abuse is not perceived by the child as being directed toward her or him. □

Reporting Maltreatment

Child Abuse Prevention, Adoption, and Family Services Act of 1988 (Public Law 100-294 *)

Federal law defines child abuse as:

- Physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances that indicate that a child's health or welfare is harmed or threatened.

States are required to have:

- Child abuse and neglect reporting laws.
- A system in place for reporting child abuse and neglect.
- Policies regarding immunity from liability.
- A system in place to adequately investigate complaints.
- Protective services available when needed.
- Policies regarding confidentiality of families needing services.

States must:

- Demonstrate cooperation among law enforcement, the courts and human service agencies.
- Appoint a guardian *ad litem* or a court-appointed special advocate (CASA) to advocate for the child in cases that require court intervention.
- Provide information to the general public regarding:
  - Accurate reporting techniques.
  - The extent of the problem of child abuse and neglect.
  - Facilities, prevention, and treatment methods to combat child abuse and neglect.
- Provide policies for reporting and responding to medical neglect (including withholding medical treatment from infants with disabilities who have life-threatening conditions).
- Develop procedures and programs within the state child protective service system to provide for:
  - Coordination and consultation for persons in healthcare facilities.
  - Prompt notification for suspicion of medical neglect (including instances of withholding medical treatment from infants with disabilities who have life-threatening conditions).
  - Provisions for the state to pursue any legal efforts to prevent withholding medically needed treatment for infants with disabilities who have life-threatening conditions.

- **Federal law defines:**
  - **A child** as a person who has not attained the lesser of:
    - The age of 18; or
    - Except in the case of sexual abuse, the age specified by the child protection law of the State in which the child resides.
- **Child abuse and neglect** as the following acts performed by someone who is responsible for the child's welfare in circumstances where the child's health or welfare is harmed or threatened:
  - Mental injury
  - Sexual abuse or exploitation
  - Negligent treatment
  - Maltreatment of a child
- **A person who is responsible for the child's welfare** includes:
  - An employee of a residential facility.
  - Any staff person providing out-of-home care.
- **Sexual abuse** includes:
  - The use, persuasion, inducement, enticement or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct
  - Rape
  - Molestation
  - Prostitution
  - Any other type of sexual exploitation of children
  - Incest with children
- **Withholding of treatment** means the failure to respond to an infant's life-threatening conditions by providing treatment that is determined by a doctor to be a reasonable medical treatment, including appropriate:
  - Nutrition
  - Hydration
  - Medication
- **Exceptions to withholding treatment** include the following instances:
  - Infant is chronically and irreversibly comatose
  - Treatment would prolong dying
  - Treatment would not be effective in correcting an infant's life-threatening conditions
  - Treatment would not help the survival of the infant
  - Treatment itself is inhumane

*** Refer to "Baby Doe" legislation in your state**

*** Your state laws are of critical importance. To receive a copy of the laws in your state, contact your state's Department of Human Services or Social Services.**

Why children don't disclose

- Feelings of shame
- Loss of trust
- Low value of self
- Unaware that activity is inappropriate
- Fear of breaking up family
- Alienation of family member
- Isolation
- Threats
- Confusion
- Dependency needs of victim
- Ill-equipped to deal with outside world
- Chaotic lifestyle

Who Is Mandated to Report?

Professionals who are mandated by law to report may vary from state to state. The most common professions include:

- All medical and hospital personnel (includes dentists)
- School personnel
- Child-care providers
- Social workers
- Mental health personnel
- Law enforcement personnel
- Residential program staff (especially those licensed by the state)
- Clergy (in some states)

Federal law specifies that:

- Mandated professionals have immunity from liability, which provides protection from civil or criminal prosecution for reporting, as long as the report was made in good faith.
- Failure to report a case of suspected maltreatment can result in legal ramifications. (Check your own state for specific information.)
- Mandated reporters are responsible for making the report to the correct authorities, not just reporting their suspicions to their immediate supervisor.

Who do mandated reporters report to?

- Local human service or social-service agency (as designated by your state)
- Local police department or county sheriff's office (as designated by your state)

What should be reported?

- Identification of the child, age, grade, address, and names of primary caregiver(s) or parent(s)
- Name of the person believed to be responsible for the abuse (if known)
- Where the alleged abuse took place (if known)
- Description of the injury or neglect, any statements made by the child, and any other observations relevant to documenting the report
- When the incident(s) took place (if known)
  - Children in this age range have very little recognition of time and can best identify time by specific incidents in their lives that are significant, such as holiday, birthdays, etc.
- Mandated reporter's name, address and phone number
- Any other staff person who witnessed the action(s) or has information

Other items to consider:

- The reporter should document, for her or his own records, the name of the person the report was made to and the date or time the report was made.
- If the child has a disability that may make communication difficult in an investigation, this information should be made known in the initial report.
  - This information is important, as a third party may need to be present to assist in the assessment or investigation. (For example, a child with a hearing impairment may need an interpreter.)
  - An interpreter may be necessary if the child's or family's native language is not English.
- Try to ensure the discussion with the child takes place in what the child views as a safe environment. Avoid settings that may have negative associations for the child, such as a time-out area or room.

When should a report be made?

- When you have "reason to believe" a child is being maltreated.
  - Reports must be made to the appropriate authorities in both oral and written form. (Consult your *state laws for time limits* on types of reports; usually immediately is defined as within 24 hours.)

False reports:

- Mandated reporters who knowingly make false reports of maltreatment are liable under the laws of their states.

Remember . . .

It is ***your responsibility*** to report the signs and symptoms of maltreatment you observe; ***law-enforcement personnel*** are responsible for investigating the suspected crime; ***social-service personnel*** are responsible for assessing the risk to the child and the severity and validity of the reported abuse.

To facilitate mandated reporting:

- Each child-care program should include reporting information as a part of staff orientation, which should include:
  - A policy that follows the law as specified in the state of residency.
  - A child-abuse report form,

Who else should report?

Parents or nonmandated caregivers are not required to report, ***but anyone can report suspected child abuse or neglect.*** The same guidelines apply as for early childhood professionals. If a child reports information that indicates abuse, or indicators of abuse or neglect are observed, report to your local law-enforcement and/or social-service agency, but do *NOT* investigate, confront the alleged abuser, or inform the child's parents, other relatives, or teachers. □

References – Reporting Maltreatment

The following resource was used in part for information about how to talk to a child when abuse is suspected :

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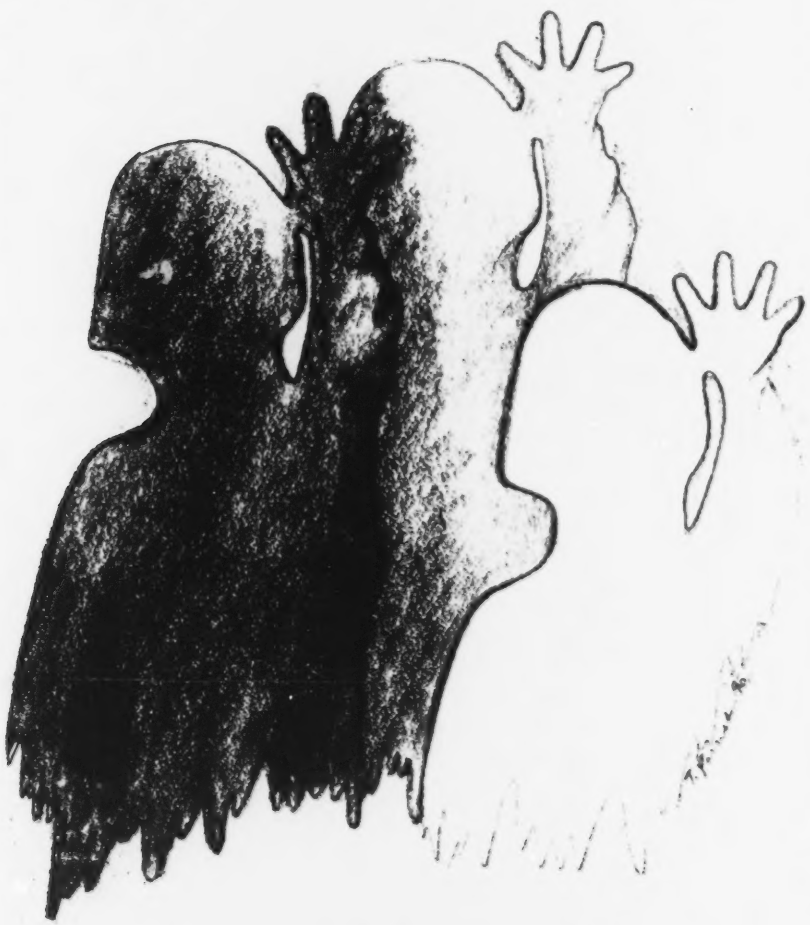

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Prevention of Child Maltreatment

Prevention programs need to be culturally diverse, ability sensitive, and gender fair to ensure reaching their full potential.

Strategies for the Prevention of Child Maltreatment

Like the effects of child maltreatment, the need for prevention services may be seen on a continuum. Three types of prevention are:

- **Primary prevention:** Programs and services promoting the general welfare of children and families and preventing the first occurrence of child abuse and neglect in a family.
- **Secondary prevention:** Programs, services, and professionals who identify children who are in circumstances where there is a high risk that abuse will occur and give assistance, as necessary and appropriate, to prevent abuse or neglect from occurring.
- **Tertiary prevention:** Services provided after abuse and neglect have occurred, which are designed to prevent the recurrence of abuse or neglect.

Development Stage	Primary Prevention	Secondary Prevention	Tertiary Prevention
Prenatal and Neonatal Stage	1. Childbirth Education 2. Childbirth and Neonatal Education for Fathers 3. General Media Information, T.V., Radio, Newspapers, Books, Magazines	1. Medical and Health Professionals 2. Family Planning Clinics 3. Neonatal Nurseries 4. Homemaking Services 5. Adolescent Parent Education — Public Schools	1. Programs for children who have been prenatally exposed to substance abuse
Infancy (0-1 year)	1. ABC Mothers Group (After Baby Comes) 2. Infant Education Groups 3. General Media Information 4. Neighborhood Child-Care Cooperatives	1. Medical and Health Professionals 2. Emergency Room Personnel 3. Maternal and Child Health Clinics 4. Guidance Center 5. At-Risk Clinics 6. Mothers Day Out Programs 7. Crisis or Respite Care Programs or Shelters 8. Mothers of Twins Support Groups 9. DHS/Child Welfare	1. Shelters 2. Foster Homes 3. Court Ordered Parent Education Groups — Nurturing Program 4. Possible Hospitalization 5. Community Multi-disciplinary Sexual Abuse Projects.
Toddler and Preschool Child	1. Parent-Child Education Programs, e.g, P.E.T., S.T.E.P., or How To Talk So Kids Will Listen . . . 2. Parent-Child Enrichment Programs — Child Guidance Clinics 3. General Medical Information Promoting Parent-Child and Family Life.	1. Parent Support Groups such as Parent Assistance Centers, Parents Anonymous 2. Parent Support Groups for Parents of Children with Developmental Disabilities 3. Preschool and Daycare Programs 4. Medical and Health Professions 5. Domestic Violence Shelters 6. Crisis and Respite Care Programs 7. Mental Health Professionals 8. DHS/Child Welfare	1. Shelters 2. Foster Homes 3. Court Ordered Counseling/Therapy 4. Court Ordered Parent Education Groups — Nurturing Program 5. Possible Hospitalization 6. Community Multi-disciplinary Sexual Abuse Projects

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Child Care and the Prevention of Maltreatment

Essential components of prevention programs

Three important areas in child-abuse prevention and maltreatment are support for the child, support for the parents, and coordination of supportive activities. One critical component for prevention projects is to insure inclusion. Prevention programs need to be culturally diverse, ability sensitive, and gender fair to ensure reaching their full capacity. Two elements are necessary for successful prevention programs: first, some measurements to provide ongoing training for providers; and second, an evaluation component to measure the effectiveness of program efforts.

Prevention and intervention programs need to fit the families of the 1990s. They need to allow caregivers and children to identify who their families consist of (rather than imposing rigid traditional concepts of nuclear or extended families). They also need to allow caregivers to identify what they need for family members and to focus on the strengths of individuals in the family.

Increasing number of children in daycare and preschool programs

Recent media coverage has alerted parents and providers to the possibility of abuse in out-of-home care or by in-home care providers. When examining the data on child care today in this country, the actual number of incidents of maltreatment by child-care providers is minimal when compared to the number of children placed in daycare and preschool environments each year. However, even one occurrence is more than parents or society should tolerate. Children have the right to be safe.

Not only are many more incidences of child abuse reported due to public awareness, more children are attending child-care and preschool programs. A significant factor is the increasing number of working mothers who are placing their children in daycare. Over the past several decades the number of working women, especially mothers of young children, has steadily increased. According to the Bureau of Labor Statistics, U.S. Department of Labor, (January 1989), in 1988:

- 51.6 percent of women worked outside the home, making up 45 percent of the total labor force.
- Of mothers of children under the age of two, 51 percent are working mothers.
- Of the 21.7 million children under the age six, 10.5 million have a mother in the work force.
- By the year 2,000, 47 percent of the national work force will be women, with 61 percent of all women working outside the home.

Challenges for child-care providers

Child-care providers, whether providing care in a home or in a child-care center, face many challenges. They include:

- Providing age-appropriate care for infants, toddlers, and preschoolers, including children with disabilities.

- Being responsible over long periods of time for children whose behaviors are challenging.
- Understanding stress in both work and family issues.
- Providing a safe environment for children in order to reduce the possibility of accidents.
- Hiring regular and substitute care providers who will ensure a safe environment for children.
- Providing nutrition and balanced meals.
- Developing adequate and clear policies in order to protect child-care providers and their families.
- Obtaining child-development information on an ongoing basis in order to understand the reasons for children's behavior.
- Understanding of children's and families' cultural and ethnic traditions and values.

Policy development

Policies that can assist in the reduction of risk for maltreatment can be incorporated into the program and reviewed with other child-care workers and with parents. Written policy development could include:

1. **Parent access to child's program.** An open-door policy allows the parents easy access to the program at any time and without notice. Specific guidelines can be established as to appropriate times that are comfortable for providers and parents or other caregivers to discuss problems and concerns.
2. **Discipline techniques.** Families need to know how negative behaviors are handled and the rules for children. Policies should outline methods not used, such as spanking, ***even*** at parent request. If such a request should arise, document the request as to who and when, and other information in the conversation. Keep a copy of this information in your files. Also, the policy should outline how conflicts between providers and families will be addressed.
3. **Incident Report Form.** Parents have a right to information regarding what happened to their child while in care. For example, when a child is knocked down and sustains an injury (bruise or scrape) or is hurt on the playground, a parent needs to have this information. Communication will also help instill parent trust and provide some protection for the child-care provider.
4. **Substitute Care.** This policy will describe important information about the qualifications in hiring substitute care and helpers for the program. It also should outline the ongoing training necessary to keep staff up-to-date on current child-care information. Substitute care providers for children with special needs should be able to document experience or education relevant to the special needs of the children they will care for.
5. **Picking up child in the parent's absence.** Before releasing a child to anyone other than a parent, a parent must identify who that person is, even in the case of an older sibling. For a noncustodial parent or caregiver, identification should be required prior to their taking the child.

These policies, once implemented, are shared with parents. A mechanism can be put in place to document that parents have reviewed the policies and indicated their understanding by signing a form upon completion of reviewal. Copies of these forms are given to the parents and the originals maintained as part of business records. If the parents' or caregivers' native language is not English, copies should be provided in their native language, as should copies of other information.

The need for advocacy in child care

According to a study released by the Child Care Employee Project, the low pay scale for teachers and early childhood child-care workers has led to a tripling of staff turnover in the last ten years (National Center for Youth Law, 1990). A child's development is enhanced when care during the first few developmental years is consistent. Child-care staff turnover rates do affect a child's development.

Indicators for child-care providers in assessing and hiring child-care workers

It is the responsibility of the provider to ensure regular and substitute care providers will maintain a safe and healthy environment for children in their care. Some indicators to be aware of in assessing applicants include:

- Favors direct supervision while attending to child's personal needs.
- Has adequate child development information and disability-specific knowledge about caring for children.
- Understands philosophies, and is not rigid, in regard to adult-child interactions, expectations for children's abilities, and discipline.
- Describes children's behavior on a continuum. (Behaviors of children can be positive or negative, but a child should not be categorized as "good" or "bad.")
- Believes in nonviolent methods of child discipline, rather than corporal punishment. (Children have the right to clear and consistent limit-setting and discipline principles that include natural consequences.)
- Believes children require freedom to develop, rather than strict, rigid control. (Power and control are prime factors in child maltreatment.)
- Does not appear to be nervous around children.
- Does not categorize, degrade, or stereotype ethnic groups or nontraditional families. (The focus for families needs to emphasize strengths, not deficits.)
- Understands and respects the cultural values and traditions of minority children with whom he or she may be working.

Even with the best policies and superb programming, the risk of being accused of maltreatment exists. □

Child-Abuse Prevention Checklists

The following is a sample of a child-abuse prevention checklist for directors of child-care programs. The checklist could be updated periodically and used by the center and program directors as a child-abuse prevention method. Documentation of all findings and corrections would be kept on file.

Child-Abuse Risk Assessment
Checklist for Child Development Center Directors

Administrative Practices

- ■ 1. Compliance with regulation is regularly reviewed and all guidelines are followed by the staff.
- ■ 2. A regulation is considered a minimum standard, and additional efforts are made to provide quality care.
- ■ 3. Written discipline policy is known and followed by all staff members.
- ■ 4. Written touch policy is known and followed by all staff members.
- ■ 5. Written policy exists for how children in attendance are accounted for at all times.
- ■ 6. Written policy exists for the transfer of responsibility of children from parent to staff at the beginning of the day, and for transfer of children from staff to parents at the end of the day.
- ■ 7. Written policy exists for obtaining permission from parents for pick-up of children by adults other than parents.
- ■ 8. Drop-ins are clearly identified and accounted for, and the procedures for transfer of responsibility are the same as those for children in daily care.
- ■ 9. Unknown adults do not have access to children.
- ■ 10. Staff-child ratios and group-size guidelines are followed.
- ■ 11. A team approach to caregiving is used.
- ■ 12. Every caregiver who is responsible for a group of children is within sight of another caregiver.
- ■ 13. A caregiver who works alone with children and not within sight of another caregiver is regularly supervised.
- ■ 14. Children are supervised at all times.
- ■ 15. Written policy for staff rest periods exists.
- ■ 16. A place exists for staff to go to and rest.
- ■ 17. Written procedures exist for dealing with suspected abuse of children by staff:
  - ■ emotional
  - ■ physical
  - ■ sexual
- ■ 18. Written procedures exist for dealing with confirmed abuse of children by staff:
  - ■ emotional
  - ■ physical
  - ■ sexual

- ☐ 19. In monitoring the center and using the checklist as a guide, do the children appear to be safe and productively, pleasantly occupied?
- ☐ 20. When walking through the center as the coordinator or directory, are observations satisfactory?
- ☐ 21. Supervisors have consistent expectations for staff members, and fairly praise and criticize.
- ☐ 22. Physical and mental health problems are recognized by all as obstacles to good team work and steps are taken to improve either problem when it arises.
- ☐ 23. Stress is recognized as an occupational hazard for all staff members and steps are taken to manage both individual and group stress.
- ☐ 24. Differences of opinion are respected when appropriate to do so, but when the well-being of children is affected such matters are dealt with promptly.
- ☐ 25. Signs of burnout and boredom are recognized and steps taken to deal with them.
- ☐ 26. Staff members recognize the need for breaks and take them without feelings of guilt.

Staff-Child Interactions

- ☐ 27. Expectations of children are age-appropriate for:
  - ☐ infants
  - ☐ toddlers
  - ☐ preschoolers
  - ☐ school-age children
- ☐ 28. Materials and activities planned for children are age-appropriate for:
  - ☐ infants
  - ☐ toddlers
  - ☐ preschoolers
  - ☐ school-age children
- ☐ 29. Expectations of children are clear and consistent.
- ☐ 30. Expectations of children are not rigid, but flexible.
- ☐ 31. Positive language is utilized in stating children's behavior.
- ☐ 32. Threats, shaming, or ridicule are never used when correcting children's behavior.
- ☐ 33. Children do not seem unnaturally well-behaved.
- ☐ 34. Children are allowed to go to the bathroom when the need arises and not just at scheduled times.
- ☐ 35. Children are not required to wait unnecessarily (e.g., go to bathroom, brush teeth, go outside, eat, have drink of water).
- ☐ 36. Toileting accidents are not punished.
- ☐ 37. Daily health check each morning includes a scan for indications of possible abuse.
- ☐ 38. Teachers and caregivers know where every child is at all times, including drop-in children.
- ☐ 39. Emphasis is directed toward managing the environment, not managing the children.
- ☐ 40. Emphasis is directed toward children's needs, not toward adult needs.

Staff-Parent Relations

Staff-Parent Relations

- ☐ 41. Written *discipline* policy is explained to all parents at the time of enrollment, and is available for review at parents' request.
- ☐ 42. Written *touch* policy is explained to all parents at the time of enrollment, and is available for review at parents' request.
- ☐ 43. Staff and parents make the transfer of responsibility directly for children in the morning and at the end of the day (e.g., eye contact, verbal).
- ☐ 44. Parents authorize in writing those other adults who may pick up their children.
- ☐ 45. Parent-teacher conferences may be initiated at any time by teachers or parents and are not scheduled only in response to crisis.
- ☐ 46. Parents are discouraged from using physical punishment at home for misbehaviors in the center.
- ☐ 47. Parents are encouraged to use community resources for personal and family problems.

Environment

- ☐ 48. Physical environment is clean and safety procedures are followed.
- ☐ 49. Materials for use by the children are accessible to them.
- ☐ 50. Staff is attentive to children on the playground.
- ☐ 51. Toileting and diapering areas are observable and not far away from the classroom area.
- ☐ 52. Access to children by unknown adults is prevented by effective management of:
  - ☐ facility
  - ☐ staffing
  - ☐ supervision
- ☐ 53. Access to children by potentially abusive staff is prevented by effective management of:
  - ☐ facility
  - ☐ staffing
  - ☐ supervision

Mary Lou Gilstad, University of Minnesota, Early Childhood Studies. Used with permission.

Child-Abuse Prevention Checklist for Children with Disabilities

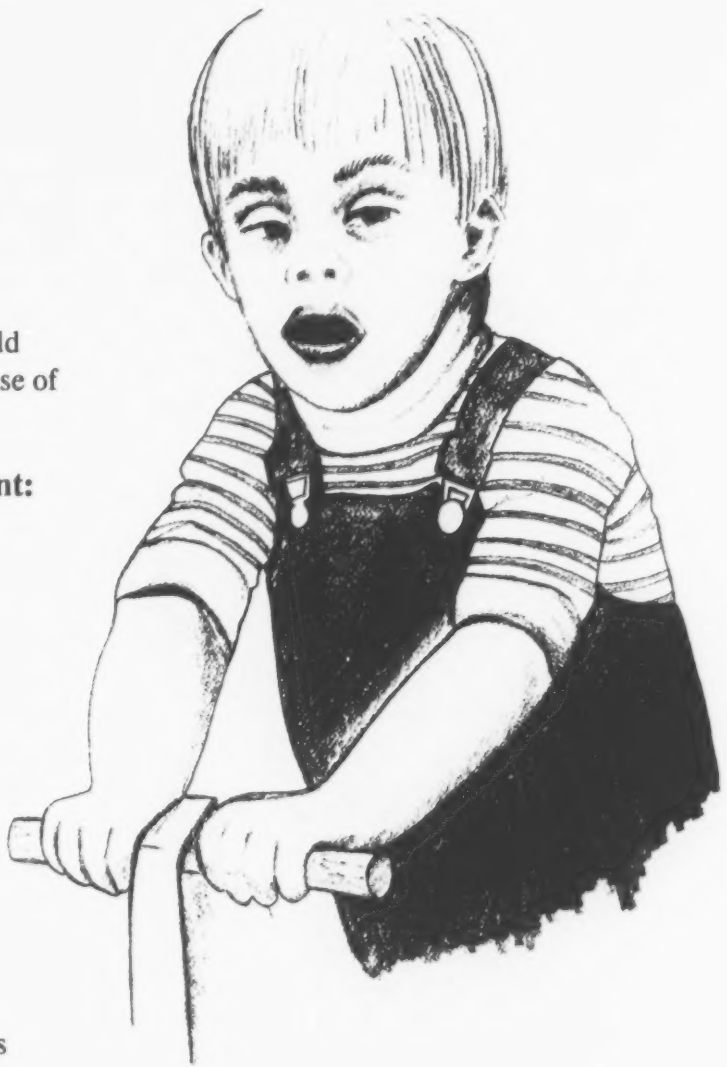
The following checklist, developed by PACER Center, is helpful to consider in working with children who have, or are at risk for, disabilities. This information would be a part of the intake of a child with disabilities. Occasionally (a minimum of every 6 to 12 months), an updated form would be reviewed with the parent or caregiver to ensure the child's needs are being met. The form could then be signed by the parent or caregiver at the time of the review and kept in each child's file.

Does the child use:

- ☐ Any adaptive equipment
- ☐ Sign language
- ☐ Any medications

What are:

- ☐ Levels of self-help skills
- ☐ Favorite foods
- ☐ Favorite toys
- ☐ Favorite activities
- ☐ Daily routines
- ☐ Techniques which soothe the child
- ☐ Emergency numbers to call in case of accident or injury



Information regarding movement:

- ☐ Is the child ambulatory?
- ☐ Does the child fall often?
- ☐ Does the child bruise easily?

Evidence of the presence of:

- ☐ Developmental delays
- ☐ Self-injurious behaviors
- ☐ Hypersensitivity to touch
- ☐ Aggressive behavior
- ☐ Extreme passivity
- ☐ Excessive masturbation
- ☐ Excessive crying
- ☐ Tantrums
- ☐ Allergies: foods and medications
- ☐ Unusual fears
- ☐ Rashes, marks, or injuries that are current

Is the child toilet trained?

☐ Yes ☐ No Toileting habits:

Is this child aware of dangerous activities and situations (for example, running out in the street, putting fingers in light sockets, etc.)

☐ Yes ☐ No

Has the child ever stopped breathing for any reason?

☐ Yes ☐ No

Are there changes I should make?

References – Prevention of Child Maltreatment

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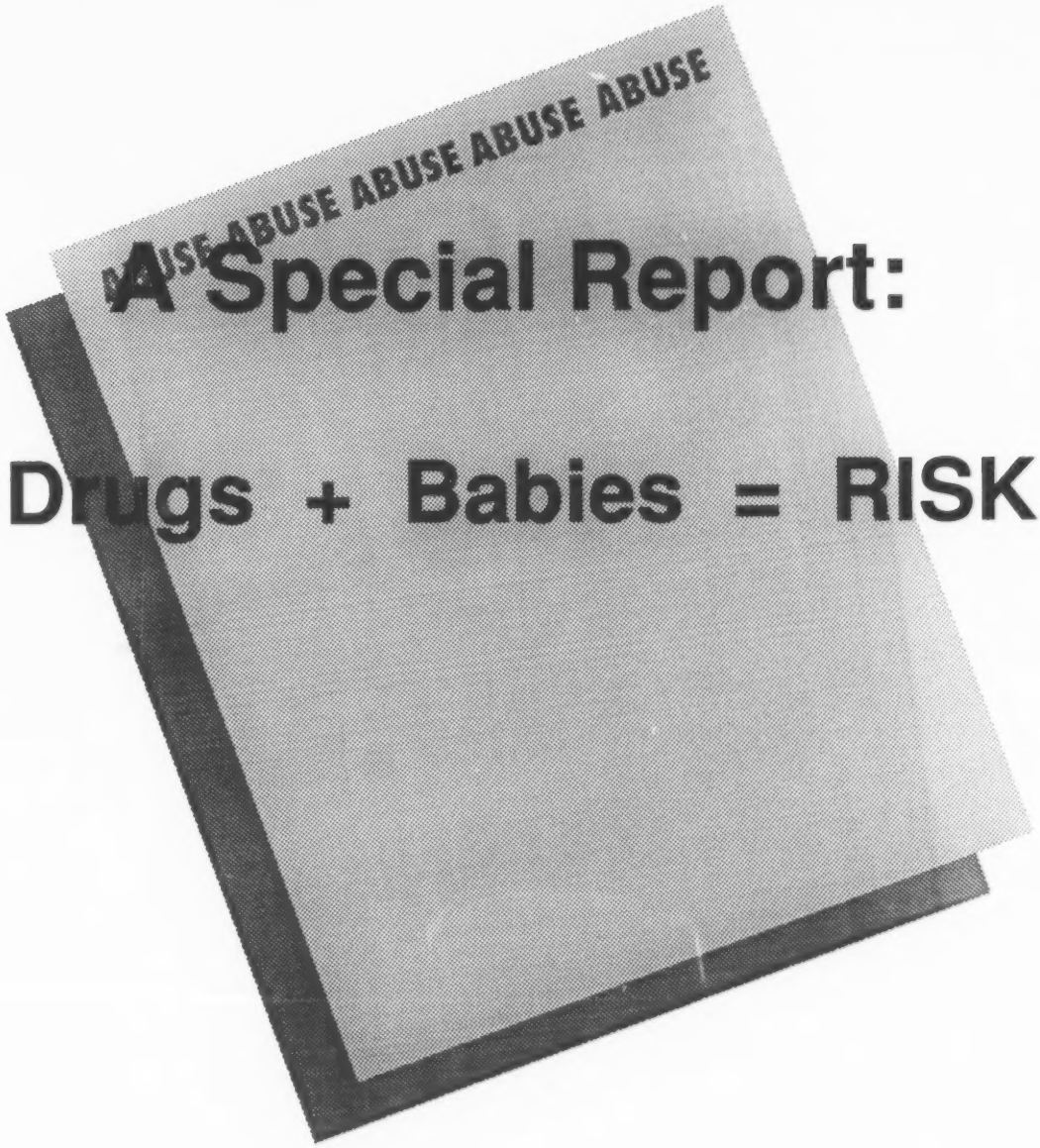

ABUSE ABUSE ABUSE ABUSE ABUSE
A Special Report:
Drugs + Babies = RISK

Reinforcing parent shame and guilt will not change the fact that these children are in trouble. The focus needs to be instead on empowering these families to maximize their children's potential.

Drugs + Babies = RISK

> ***. . . Babies are the link from one generation to the next. It is only through . . . children that the unique aspects of each culture can live and flourish.***
>
> ***— Ann Pytkowicz Streissguth, PhD***

The only sure way for infants to avoid the negative effects of drugs and alcohol is for mothers to restrain from *ANY* substance intake. It is projected that by the year 2,000, American society will see the effects of cocaine and crack use in anywhere from one-half million to over four million children (National Council, Spring, 1990). According to the Children of Alcoholics Foundation, approximately 28.6 million Americans who are alive today were raised by at least one alcoholic parent. It is believed that currently 6.6 million children are living with an alcoholic parent (Thompson, 1989-1990).

According to the National Committee for the Prevention of Child Abuse, in 68 percent of child-abuse and neglect reports, substance abuse was involved (Thompson, 1989-1990). It is essential that policies, resources, and programs address the issues relative to the emergence of this far-reaching social problem.

While prevention strategies are critical for the generations to come, society is currently faced with the effects of drugs and alcohol in children ages birth through five. This chapter will address the effects of addiction on today's parents, fetal alcohol syndrome, fetal alcohol effects, the effects of cocaine and crack use on young children, proposed solutions, and pediatric AIDS.

Addictive Diseases

Characteristics of caregivers

The following characteristics are described by C. Butler (1990):

- **Disregard of consequences.** Although many caregivers have been warned by a doctor or partner or have suffered from the loss of a job, they continue to use substances despite the consequences.
- **Compulsive behaviors.** Psychological dependence on drugs and preoccupation with using drugs leads to compulsive behavior. When caregivers need to escape the unpleasant things in their lives or decrease feelings of anxiety, pain, and frustration, they use mood altering chemicals to provide relief. Drug-users also often develop a preoccupation with the mere image of escaping through the use of drugs.
- **Loss of control.** Loss of control is a known indicator of alcoholism. Loss of behavioral and emotional control occurs with the ingestion of a determinate amount of any mood-altering chemical. It is the loss of behavioral control that may and often does result in child maltreatment.

- **Physical addiction.** When caregivers try to reduce their intake of or abstain from taking a substance, a physical addiction may be apparent.

When one or more of these characteristics is present, a person is said to be chemically dependent. The whole family is at risk when one of its members is chemically dependent. Each member adopts certain survival skills to maintain safety within the family and to avoid the rage of the person who is using drugs or alcohol.

Effects of Alcohol on Children

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) are the results of alcohol consumption during pregnancy. Their characteristics are described below.

Fetal Alcohol Syndrome (FAS)

Fetal Alcohol Syndrome is a group of physical and behavioral problems caused by prenatal alcohol exposure. Diagnosis is based mainly on physical symptoms. When a mother consumes alcohol, the amounts of alcohol in the bloodstreams of the mother and baby are equal. Human bodies do not have any way to divert the alcohol from the growing fetus. *The only way to prevent alcohol from causing damage to the infant is not to drink alcohol during pregnancy (or when breastfeeding, since alcohol in the mother's system is also in breast milk).*

Heavy alcohol use disrupts the proper development of organs in the fetus. The brain and spinal cord can be affected by drinking alcohol at any time during the pregnancy. Mothers who drink heavily during pregnancy risk bearing infants with FAS. Developmental delays and mental retardation are common in FAS.

The following are physical symptoms of alcohol exposure used to diagnose FAS.

- Characteristic facial features include:
  - Smaller head circumference
  - Small and narrow eye openings
  - Flat midface (cheekbones)
  - Flat upper lip (no bulge)
  - Thin upper lip
  - Excess tissue on the eyelids (epicanthic folds)
  - Outer ear anomalies
  - Lowered nasal bulge
  - Short nose
  - Eyes appear to be set far apart due to flattened nasal bridge and small eyes

Note: Some of the above physical features are characteristic of ethnic groups; care needs to be taken not to confuse ethnic characteristics with those of FAS.

- Other physical characteristics include:
  - Defects in growth patterns (small bodies, thin arms, etc.)
  - Central nervous system dysfunctions
  - Increased frequency of heart defects, anomalies of joints and limbs and other malformations

Any one of these characteristics, taken by itself, would not identify the presence of FAS, but in combination, and when there is a history of maternal drinking, these symptoms may be indicators for diagnosis.

Effects of FAS/FAE in infancy and early childhood

When the physical symptoms of FAS are not all present, but behavior and neurological effects exist, the child may have Fetal Alcohol Effects (FAE). FAS is only the tip of an iceberg: FAS and FAE differ only in the extent of physical symptoms. Considerable overlap is found in the IQ scores of the two groups, and they have very similar behavioral and cognitive characteristics. The effects of FAS and FAE are lifelong.

Infants and young children with FAS/FAE may have:

- Poor sucking response.
- Failure to thrive.
- Distractibility and hyperactivity.
- Delays in walking and language development.
- Delayed toilet training.
- Difficulty following directions.
- Temper tantrums.
- Inability to screen out irrelevant stimuli.
- Sleep disturbances.
- Speech delays.
- Hearing loss.

Older children with FAS/FAE may have the following behaviors:

- Poor impulse control
- Poor judgement
- Poor concentration/attention problems
- Restlessness
- Vulnerability
- Lying, cheating, stealing, without understanding consequences
- Challenging behaviors, often due to an inability to communicate effectively

Finding help for families

Many of the behaviors related to FAS/FAE may mimic child-maltreatment indicators. Reinforcing parent shame and guilt will not change the fact that these children are in trouble. The focus needs to be instead on empowering these families to maximize their children's potential. In families with FAS, more maternal deaths and disabilities, more family break-ups, more hyperactivity and attention deficits, lower IQs, and lower ceilings for academic achievement are encountered.

Ways to help families and their children include:

- Providing information and education to assist in understanding the problems of children with FAS/FAE
- Finding help at schools:
  - Finding an advocate for the child
  - Exploring placement options in preschool programs
  - Providing for an individualized curriculum specific to the child
  - Focusing on development of the child's functional skills (such as daily living and social skills)
  - Encouraging opportunities to explore strengths of children
  - Educating schools about FAS/FAE
- Utilizing community resources
  - Finding a therapist and/or case manager
  - Finding specialized programs
    - Summer programs
    - Anger management
    - Social skills training
  - Finding resources for respite care
  - Finding financial assistance
  - Finding legal services
- Improving relationships at home
  - Maintaining consistent structure and supervision
  - Providing a balance between structure and opportunities to make decisions
  - Learning effective behavior management techniques, such as:
    - Strategies to cope with crises
    - Effective communication skills
    - How to establish exchange systems (for example, allowance, treats)
    - How to create opportunities to make choices
  - Encouraging constructive leisure activities
  - Learning ways to have fun together as a family
- Planning for the future
  - Planning for longer supervision and dependency needs
  - Encouraging skills training
  - Planning financial management
  - Planning for supervised living as needed
  - Planning for disability and medical coverage as needed
- Working to improve community resources
  - Network
  - Advocate
  - Educate

Early intervention

Early intervention for children with FAS/FAE is critical. Early diagnosis facilitates the early introduction of services and prevents increased difficulties—and costs—in childhood, adolescence, and adulthood. Treatment options for pregnant mothers need to be expanded to include both inpatient and outpatient services, which include respite care and child-care provisions for other children in the family.

Early intervention includes:

- Support for mother and family sobriety.
- Early identification and diagnosis.
- Education of parents in regard to physical, psychological, and social needs of the child.
- Early introduction of appropriate educational programs (which results in a decreased level of challenging behaviors).
- Monitoring of the child's physical development and health.

Advocacy for needs of mothers who drink during pregnancy

According to the National Council on Alcoholism, 60 percent of all women over age 18 ingest alcohol, 5 percent are heavy drinkers, and 55 percent are moderate drinkers. The estimated cost of providing services from infancy through adulthood for people born with FAS is greatly increasing. In 1989, the cost factor was estimated to be $1,400,000 per FAS birth across the lifespan.

Controversy surrounds the laws that mandate reporting of mothers who test positive for chemicals during pregnancy. While such mandates may have appeal as an "easy fix," two areas need to be highlighted:

1. The major gaps in our healthcare delivery system where adequate services are not available to meet the needs of these women.
2. The fear that these laws will produce a subculture of mothers who will not seek prenatal medical attention and increase the risk to both mother and infant.

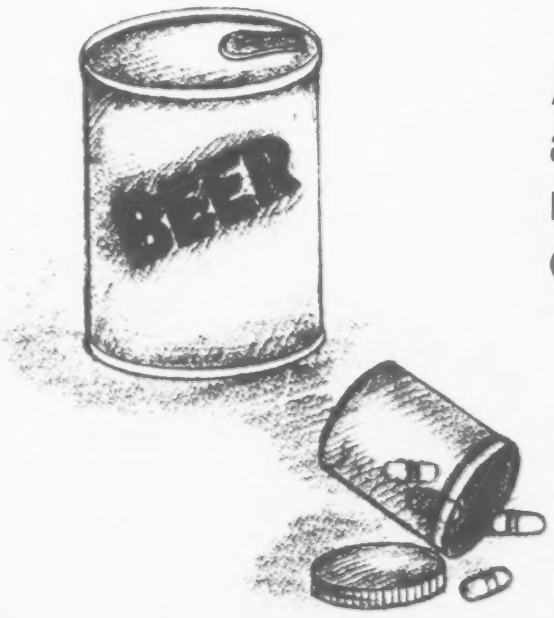
Presentations by Donna Burgess, PhD, Research Assistant Professor, University of Washington, Seattle, Washington, and Robin LaDue, Clinical Psychologist, Seattle, Washington, at the Bureau of Indian Affairs (BIA) Early Childhood Conference, July, 1990, Minneapolis, Minnesota, were used as resources for in part for information about FAS/FAE. (Used with permission.)

Effects of Cocaine and Crack on Children

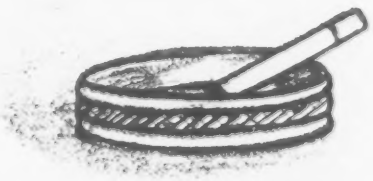
Cocaine and crack (a smokable form of cocaine) deplete the brain's supply of dopamine—an essential neurotransmitter needed to experience pleasure. Within minutes after using the drug, euphoria is replaced by severe depression, irritability, and paranoia. Crack can become addictive within a few weeks. Crack also can trick one's body into believing the body is healthy and has been well fed and rested (Koppelman & Jones, 1989).

Effects of Chemical Dependency

- Substance use despite consequences
- Compulsive behavior
- Loss of self-control
- Physical addiction



All family members are at risk . . . when one member is chemically dependent.



(CADAC) C. Butler, 1990

Due to the increase of drug use and addiction among women of childbearing age, the number of children exposed prenatally to drugs—especially crack and cocaine—has increased significantly in recent years. According to researchers, the oldest children in strict clinical research trials are still younger than three years of age. It is essential to consider the needs of these children as programs are developed.

According to researchers, anywhere from 50,000 to 375,000 babies in the United States may be prenatally exposed to drugs annually. Most infants exposed to drugs prenatally were exposed to more than one drug. It is therefore inaccurate and sometimes dangerous to label children as crack babies, since the effects may be from the use of multiple drugs and compounded by poverty.

The effects of cocaine on babies can be the same whether the mother uses the drug once or is a regular user. Of the two million reported cases of child abuse and neglect, 50 to 90 percent of the cases involved substance abuse, often cocaine and crack (Cocaine, 1990).

Prenatal effects of mother's drug use on infants

Children prenatally exposed to cocaine or crack have been described as "kids wired for 110 volts, living in a 220 volt world" (Rist, 1990). Caring for, talking to, and teaching these children can be extremely difficult and stressful. These infants definitely do not get the best start in life.

Normally, the best time for an infant to learn is when he or she is in an alert, yet calm state. Cocaine-exposed infants may not develop that relaxed state. Even when the infants are calm, caregivers may fear disturbing them because it might cause prolonged irritability, which would negatively affect the infant's interactions with those charged with her or his care or environment.

Some drug-exposed babies are born prematurely. When used by a pregnant woman, cocaine constricts the blood flow to the fetus, cutting off both nutrition and oxygen, which can cause miscarriage, stillbirth, and premature delivery, because the use of cocaine may bring on uterine contractions. The earlier the child is born preterm, the greater the cost to the infant and to society.

Cocaine use can cause prenatal damage resulting in:

- Prenatal strokes, which are caused by brain vessels that burst.
- Malformation of kidneys and limbs.
- Damage to central nervous system and digestive systems.
- Deformed heart and lungs.

The most severe damage to the child is during the first three months of pregnancy, the critical time of organ development.

Effects on families of toddlers and preschool children

Toddlers and preschoolers blossom as they creatively set out to explore their relationships and environment. When cocaine is used by parents or caregivers, the ability to form healthy attachments with their children may be impaired. The families of these children are altered because caregivers lose the ability to protect or advocate for the children. The financial drain of purchasing drugs puts children at extreme risk for poverty and, subsequently, the negative effects of living in poverty. The children are not the focus of their caregivers; the drug becomes the focus instead.

Indicators for early intervention: infants, toddlers, and preschool children

Many postpartum (following birth) infants show a variety of symptoms that may affect their social and emotional development. The following list of symptoms is by developmental category.

Motor and neurological development:

- Tremors when reaching, being easily startled
- Eyes not able to easily follow movement
- Difficulty in paying attention to people and objects
- Blanking out, staring spell, unusual eye movement
- Difficulty picking up things, using crayons, pencils, stacking blocks, etc. (fine motor dexterity difficulty)
- Clumsiness when crawling, walking, running, jumping, etc. (gross motor clumsiness)
- Hypersensitivity and irritability to touch and surroundings

Affective and behavioral development:

- Rapid shifts of emotion, for example from being quiet to crying loudly or acting irritable
- Irritable, hypersensitive, explosive and impulsive behaviors
- Diminished emotional response, decreased laughter (flat affect)
- Difficulty in comforting self and in being comforted
- Difficulty with transitions and changes
- Increased testing of limits
  - Insists on doing tasks on own terms
  - Continually refuses to obey or respond to simple commands
  - Easily becomes overexcited, cannot calm down (difficulty in self-regulating behavior)

Social/attachment development:

- Decreased eye contact with peers/adults
- Doesn't use gestures often to communicate with others
- Does not have fear or anxiety about being separated from parents or primary caregivers; no fear of strangers
- Attaches easily to strangers
- Aggressive with peers
- Does not follow verbal directions well or respond well to verbal praise
- Does not seek comfort, praise, and recognition from adults
- Does not ask parent or caregiver for help in getting toys, a drink, etc.

Problem-solving, attention, and concentration strategies:

- Easily distracted from tasks and attention by environmental noises and movements
- Difficulty in problem-solving situations
  - Impulsive
  - Gives up easily
  - Lacks problem-solving strategies, such as trial and error, ability to look at parts of a problem and solve (for example, putting together a puzzle)

Delayed language development:

- Fewer spontaneous sounds from early infancy (cooing, babbling, etc.)
- Doesn't learn to speak words as soon
- Decreased use of words or gestures to communicate as readily
- Prolonged use of infantile articulation ("baby talk")
- Difficulty in finding the right word(s) to express a want or need

Play:

- Wanders aimlessly rather than playing spontaneously
- Cannot organize own play, appears confused, difficulty selecting toys and focusing on play activity
- Easily overstimulated by too many things and people and too much noise
- Has difficulty with peers in unsupervised play

Physical problems:

- Susceptible to a weakened immune system, which can cause chronic upper respiratory problems and infections and increase the chance of:
  - Development being impaired.
  - Infection due to mother's having sexually transmitted diseases.

Some effects on community

- With the use of drugs, steady increases in child mortality rates are occurring in both rural and metropolitan areas where rates had remained stable for ten years.
- "Boarder babies" is a term used to describe infants whose primary caregiver has abandoned the child at the hospital due to addiction issues. These children are truly at risk, as most hospitals and child welfare agencies have no authorization to place these children in a better environment. Placement is also hampered because of behavioral and physical problems. By the time adoption can be an option, these children are older and placement is difficult.

Prevention

What needs to be done

A systemwide emphasis on primary prevention is the only sensible approach to the problems created by cocaine use.

Prevention plans should incorporate:

- Public education.
- Outreach and intervention with target populations.
- Empowerment of people in all cultural and social groups to plan and implement public education and prevention programs in their own communities.
- Decriminalization and treatment programs for drug-using pregnant women.
- Increased investment in prenatal and early childhood healthcare programs.
- Improved legislation to help place abandoned children in healthy environments.
- Collaboration between health, social service, and education sectors.

The solutions are not simple. Prevention of drug exposure will provide the ideal results for both adults and children. Society, however, will continue to struggle with children already born who are on the continuum of effects resulting from the use of drugs and alcohol.

Needs of drug-exposed infants, toddlers, and preschool children

Infants and preschool children need to:

- Feel secure in a healthy and safe environment.
- Develop or enhance primary and trust relationships.
- Be nurtured and grow in a positive social environment where satisfying relationships with children their own age and adult caregivers can be developed.
- Develop effective spoken and nonspoken communications skills.
- Improve self-concept and self-esteem.
- Express feelings and perceptions, and develop creativity through music, art, drama, and dance therapy.

The Needs of Drug-Exposed Infants and Preschool Children were developed by Operation PAR's Child Development and Family Guidance Center and are adapted from a reprint in *Cocaine Babies: Florida's Substance-Exposed Youth.*

Protective factors to be built into a classroom for at-risk children

Respect:

A setting composed of nurturing adults who are respectful of the children's work and play space, do not make unrealistic demands, and do not unpredictably appear and disappear. Adults, such as a speech and language therapist or psychologist who would not be in the classroom daily, should reintroduce themselves and let children know when they will reappear.

Routines:

Providing continuity and reliability through routines and activities that occur in predictable order strengthen the child's self-control and sense of mastery over the environment.

Regulated limit-setting:

The number of explicitly stated rules should be limited. The children are encouraged to explore and actively engage in their social and physical environment.

Flexible room environment:

It should be possible to remove (reduce stimuli) or add (enriching activity) classroom materials and equipment.

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Transition time plans:

Transition time between classroom events should be a planned activity and have a beginning, middle, and end. This time is one of the best to teach the child how to prepare and cope with change and ambivalence.

Adult/Child ratio:

The ratio should be high enough to promote attachment, predictability, nurturing, and ongoing assistance in learning appropriate coping styles.

Attachment:

A high-risk child may have a history of poor attachments and trust. The teacher should accept each child as he or she comes. The degree to which a child may trust herself or himself and others depends on the quality of the care received. Inconsistent, inadequate, or rejecting care fosters mistrust, fear, suspicion, apathy, or anger toward the world and people in general.

Feelings:

The child should be allowed to recognize that her or his feelings are real and valid. Being understood facilitates self-esteem and promotes willingness to function within prescribed limits. Teachers must accept that children have negative and positive feelings which are real, important, and legitimate. In dealing with misbehavior, the first priority should be to acknowledge what the child seems to want before dealing with the misbehavior.

Mutual discussion:

Talking about behavior and feelings (with empathy rather than judgement) validates the child's experiences and sets up an accepting atmosphere. Permission to have feelings leads to increased ability to distinguish between wishes and fantasies on the one hand and reality on the other. Verbal expression allows the child to integrate past and present events and leads to increased ability to modulate behavior, gain self-control, and express her or his feelings.

Role model:

The teacher must understand that establishing individual trusting relationships leads to the teacher becoming an important person and her or his behavior is likely to be imitated.

Peer sensitivity:

The teacher must be aware that a high-risk child becomes sensitive and aware of the needs and feelings of others only by repeatedly having her or his own needs met.

Decision-making:

Freedom to choose and take responsibility for choices (gradually expanded as the child's abilities develop) promotes self-esteem, problem-solving mastery, and moral values.

Indicators for Early Intervention Services: Infants, Toddlers, and Preschoolers and Protective Factors to be Built into a Classroom for At-Risk Children were developed by the Program for Children Prenatally Exposed to Drugs (PEDS) Team, Los Angeles Unified School District, Division of Special Education (PED Team: Carol Cole, Victoria Gerrara, Marci Blankett Schoenbaum, Teachers; Deborah Johnson, Psychiatric Social Worker; Rachelle Tyler, M.D.; and Valerie Wallace, Psychologist), and appear as reprinted in *Cocaine Babies: Florida's Substance-Exposed Youth*. (Used with permission.)

Proposed Solutions and Questions

Many proposed solutions carry with them new questions and moral dilemmas. The following chart summarizes some solutions and their possible drawbacks.

Proposed Solutions	Possible Drawbacks
Treat the pregnant, cocaine-using women as criminals, either prosecuting them for acts committed toward their unborn children, or jailing them to prevent further prenatal exposure to cocaine.	"If you jail one woman, the only lesson you teach women is to stay out of the prenatal healthcare system." —Ira Chasnoff, Northwestern University Medical School It infringes on the civil rights of the mother. A discussion of the rights of the fetus raises abortion issues.
Offer drug treatment to cocaine-addicted women.	This solution assumes they want and will accept treatment. The consensus is that those most in need of treatment are the least likely to want it. Their priority is to get more cocaine, not prenatal care or drug treatment. Some people seeking treatment are turned away because of lack of treatment options, which means that forced treatment for some makes little sense. Does this proposal include the right to detain any pregnant woman in order to assess her for chemical dependency?
Train doctors in order to encourage them to report cases of drug-using pregnant women.	Doctors are afraid of losing patients when they report them. They also fear that other women will not use prenatal services if they know they may be reported.
Increase public education, with the message that cocaine can do permanent harm to an unborn baby. Evidence indicates that not all pregnant women realize this fact.	Typical public education models do not seem to provide ways to get information to drug-users. Do they read the paper, watch television, listen to the radio? Raises the need to consider support services to families to prevent use of drugs in the first place, for example, adequate housing, health insurance, child care, employment opportunities, etc.

Center for Early Education and Development, University of Minnesota. Used with permission.

AIDS: Birth to Five Years

AIDS stands for Acquired Immune Deficiency Syndrome, which is the final stage of infection of the Human Immunodeficiency Virus, or HIV. AIDS is a tragic disease. Children throughout the United States and the world are vulnerable to contracting AIDS. AIDS can destroy an infant's and child's physical and emotional health and death is its final outcome.

AIDS in babies and young children is closely associated with drug abuse among pregnant women and their partners. The majority of children with AIDS become infected through their mothers' use of drugs. Babies born with AIDS usually die in the first two years of life. Babies infected with HIV are at risk for neurological and physical disabilities. The problem of AIDS is a problem of the whole society and needs to be addressed as such.

Facts about Pediatric AIDS

Fact: Babies born with AIDS who have contracted the disease during the first trimester of a woman's pregnancy usually die before 18 months (average age).

Fact: Of all HIV-infected infants, 60 percent contract the disease as a result of their mother's drug use.

Fact: Of all HIV-infected babies, 95 percent are born with or may develop neurological impairments.

Fact: Of all children with HIV, 25 percent develop LIP, a severe infection that results in damaged lungs.

Fact: Drug usage by the mother often destroys her ability to adequately care for the child and family (Susser, 1990).

Fact: Children born to mothers who are HIV positive have a 40 to 50 percent chance of getting AIDS.

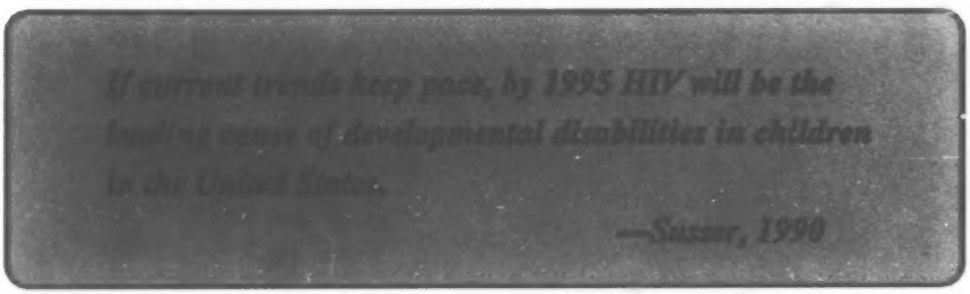
Fact: AIDS is now the fifth leading cause of death in children (Satterlee, 1990).

How do HIV and AIDS affect the human body?

HIV kills the white blood cells that are needed for our bodies to ward off disease and are a crucial part of our immune system. Without these cells, the body can be invaded by infections that lead to pneumonia and cancer; damaging diseases to the central nervous system such as meningitis may also occur. The virus can and does attack the brain.

What disabilities can result from a child contracting HIV and AIDS? According to research at Albert Einstein College of Medicine and the Rose F. Kennedy Center (cited in Susser, 1990):

- 73 to 95 percent of children with AIDS are either born with or develop neurological impairments and developmental disabilities.
- 50 percent of the infected children develop an acquired microcephaly, a smallness of the head, with accompanying cognitive defects.
- 20 percent of the children develop:
  - Severe spasticity.
  - Progressive dementia (a deterioration of mental state).
  - Loss of development previously attained.


If current trends keep pace, by 1995 HIV will be the
leading cause of developmental disabilities in children
in the United States.
—Susser, 1990

Poverty, young children, and AIDS

- Providers need to be aware that drug use is a major factor in contracting AIDS, and that families in poverty are at greater risk for both drug use and AIDS (National Center, 1990).
  - In 1987, white children comprised 70 percent of all children under six and combined children of color comprised the remaining 30 percent; yet 2.1 million white children were poor, while 2.9 million children of color were poor, making the proportion of young children of color who live in poverty far higher than their white counterparts (*Demographics in the 1990s*, 1990).
  - In August, 1988, minority-group children represented 80 percent of all U. S. reported AIDS cases among children under five (National Center, 1990).
  - Because of the high incidence of AIDS among young children of color, providers need to:
    - Develop culturally competent, community-based service systems.
    - Acknowledge and understand cultural beliefs and values that are different from their own.
    - Empower people of color to plan and implement public education and prevention programs in their own communities.

Circle of Support

- Support
- Resources
- Care Options
- Community Education

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What do children with AIDS and their families need?

These children do not have lengthy life expectancies. Extra efforts must be made to reach out to these children and families with nurturance, understanding, empathy, and support.

- In cases of drug addiction, families need support to become nonaddicted or, for non-using family members, not to support the drug use in any way or be codependent.
- Families need recognition that the family process of grieving is the same as for any family experiencing the death or loss of a family member.
- Families must be provided with the resources necessary to promote health and well-being, such as financial and medical interventions, lessening the degree of isolation, and providing adequate emotional support. Adequate and culturally competent case management also needs to be provided.
- Service providers need to recognize families' time and energy restraints and provide caregivers with adequate substitute care.
- The care options for these children need to be expanded so their world can be as consistent, nurturing, and loving as possible.
- Providers must obtain information, education, and knowledge, so that the fear and hysteria often associated with AIDS does not hamper the creation of support programs to meet families' needs.

For more information about Pediatric AIDS, contact your local social service program and/or public health department. □

References—A Special Report: Drugs + Babies = RISK

Butler, C. (May 29, 1990). OPINION: Alcoholism IS a Disease. SpecialNet Substance Abuse Bulletin Board. (SpecialNet is managed by GTE Education Services, Inc., 2021 K Street NW, Suite 215, Washington, D.C. 20006 202/835-7300.)

Cocaine: A Growing Problem. (April, 1990). *Fact Find,* No. 4. (Published by the Center for Early Education and Development, University of Minnesota, 226 Child Development Building, 51 East River Road, Minneapolis, MN 55455-0345).

Demographics in the 1990s: Implications for Services to Young Children with Special Needs. (1990). Chapel Hill, NC: NEC*TAS (National Early Childhood Technical Assistance System). (Available from PACER Center, 4826 Chicago Avenue South, Minneapolis, MN 55417.)

Florida Department of Education, Prevention Center. (1990). *Cocaine Babies: Florida's Substance-Exposed Youth.* Tallahassee, FL: Author. (Available from Florida Education Center, Tallahassee, Florida 32399-0400 904/488-7835.)

Koppelman, J. & Jones, J.M. (Fall, 1990). Crack: It's Destroying Fragile Low-Income Families. *Public Welfare,* p. 13. (Published by the American Public Welfare Association, 810 First Street NE, Suite 500, Washington, D.C. 20002.)

National Center for Children in Poverty (NCCP). (1990). *Five Million Children: A Statistical Study of Our Poorest Young Citizens,* p. 52. New York: Columbia University, School of Public Health. (Available from NCCP, Columbia University, 154 Haven Avenue, New York, NY 10032.)

National Council on Disability. (Spring, 1990). HHS Releases Report on Crack Babies. *Focus,* p. 1. (Published by the National Council on Disability, 800 Independence Avenue SW, Suite 814, Washington, D.C. 20591 202/267-3486.)

Rist, M.C. (January, 1990). The Shadow Children. *American School Board Journal,* p. 19.

Satterlee, N. (July, 1990). Pediatric Aids [Report from the 23rd Annual Gatlinburg Conference on Research and Theory in Mental Retardation and Developmental Disabilities, April 1990.] *Institute for Disabilities Studies,* 4(7). (Published by the Institute for Disabilities Studies, 2221 University Avenue SE, Suite 145, Minneapolis, MN 55414 612/627-4500.)

Streissguth, A.P. (1986). Alcohol and Motherhood: Physiological Findings and the Fetal Alcohol Syndrome. *Women and Alcohol: Health-Related Services* (Research Monograph No. 16, p. 215). Rockville, MD: U.S. Department of Health and Human Services.)

Susser, P. (Speaker.) (1990). Speech on Pediatric AIDS. SpecialNet NECTAS Bulletin Board. (For more information contact Phyllis Susser, Executive Director, Herbert G. Birch Services, 145-02 Farmers Boulevard, Springfield Gardens, NY 11434 718/528-5754.)

Thompson, J.N. (Winter, 1989-1990). Drug Abuse and Child Maltreatment: A Clear and Present Danger. *Protecting Children,* p. 4. (Available from the American Humane Association, 9725 East Hampden Avenue, Denver, CO 80231-4919.)

National Hotlines

Drug use during pregnancy

Offers confidential information about the effects of drug use during pregnancy and referrals for treatment.

1-800-327-[illegible] in Illinois, Indiana, Kentucky, Michigan, Minnesota, Missouri, and Wisconsin.

1-312-9[illegible], M-F, 9-5 central time, for other states.

AIDS hotline

1-8[illegible] for a taped message

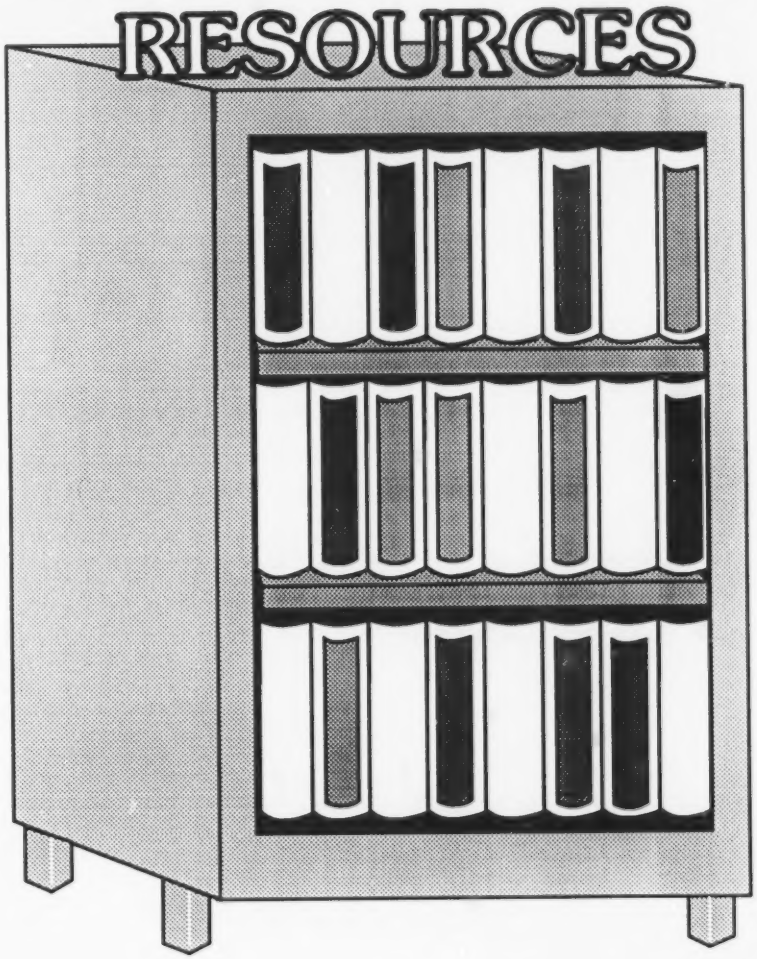
1-800-[illegible] in Spanish

1-800-AIDS-TTY for hearing impaired

1-800-[illegible] for a counselor

1-[illegible] Public Affairs Office, United States Department of Health and Human Services, Public Health Service, Center for Disease Control

RESOURCES



Resources for Teaching Young Children About Abuse

Teaching personal safety to young children is difficult. It is the adult's responsibility to protect the child, not the child's responsibility to protect himself or herself. Nonetheless, materials have been developed to help young children understand when they may be abused. The following resources about child abuse prevention and treatment are appropriate for children three years and older.

Please note: PACER does not endorse or promote any particular book or curriculum listed. Before you use any of these materials, we urge you to personally review the books or curricula described. These are some of the materials that are available.

Bassett. *My Very Own Special Body Book.* (C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, 1205 Oneida Street, Denver, CO 80220 303/321-3963.)

Approaches sexual abuse prevention in a positive way. Preschool through grade three.

Baird, Kristin. (1986). *My Body Belongs to Me.* (American Guidance Service, Circle Pines, MN 55014-1796.)

Created to help children develop a healthy self-concept and feel good about their bodies. Preschool.

Bass, Ellen & Betz, Marti. (1981). *I Like You to Make Jokes with Me, But I Don't Want You to Touch Me.* (Lollipop Power, Inc., P.O. Box 1171, Chapel Hill, NC 27514.)

Narrated by Sara, a preschooler who learns to say "No" to touching when it makes her feel uncomfortable; a good lead-in for the parent or teacher who wants to address "good" and "bad" touching.

Berenstain, Jan & Stan. (1982). *The Berenstain Bears Get in a Fight.* First Time Books. New York: Random House.

After causing a family commotion when they fight with each other, the Berenstain cubs learn that sometimes even the best of friends don't get along. Preschool, elementary.

Berg, Eric. (1985). *Touch Talk.* (Network Publications, 1700 Mission Street, Suite 203, P.O. Box 1830, Santa Cruz, CA 95061-1830.)

Uses charming, cartoonlike characters to teach children to be aware of a wide range of different kinds of touch; to be read with children; adult guide available. Preschool, elementary.

Blank, Joani & Quackenbush, Marcia. (1983). *A Kid's First Book About Sex.* (Yes Press [Down There Press], P.O. Box 2086, Burlingame, CA 94011-2086.)

Focuses on how a child feels about the sexuality of her/his body. Preschool, elementary.

Brown, Laurene Kram & Mat. (1986). *Dinosaurs Divorce, A Guide for Changing Families.* (Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32757 1-800-892-KIDS.)

Buschman, Janis & Hunley, Debbie. *Strangers Don't Look Like the Big Bad Wolf.* (Chas. Franklin Press, 7821 175th Street SW, Edmonds, WA 98020 206/774-6979.)

An abduction-prevention book for preschoolers: Molly learns how to be responsible for her own personal safety in a number of situations.

Child Abuse Research and Education Productions. (1984). *Trust Your Feelings.* (Care Productions, Box L #8, Twelfth Street, Blaine, WA 98230.)

A book to help children understand the different types of feelings and how to handle them. Preschool, elementary.

Children's Institute of Kansas City. *The Wonder What Owl.* (Children's Institute of Kansas City, 9412 High Drive, Leawood, Kansas 66206.)

A story to help young children learn about sexual abuse. Ages 3-7.

The Committee for Children. *Talking About Touching With Preschoolers.* (The Committee for Children, 172 20th Avenue, Seattle, WA 98122 206/322-5050.)

Thirty weekly lessons: simple and effective illustrations or photographs help the teacher use the self-contained teaching units. Guide notes on the back of each story or picture clarify specific objectives: teacher comfortably can use suggestions to guide discussion. (Has also been used successfully with students who have learning disabilities and for educable mentally retarded students.)

Davis, Diane. (1984). *Something is Wrong at My House.* (Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32757 1-800-892-KIDS.)

Gives children living in violent homes ideas, through words and pictures, about how to take care of themselves. Ages 4-12.

Dayee, Frances. *Private Zone.* (1982). (Charles Franklin Press, 18409 90th Avenue W., Edmonds, WA 98020 206/774-6979.)

Read-aloud book for young children teaches youngsters about their private zones and encourages discussion between the adult and child reading the book together. Ages 4-10.

Ives, Sally Blakeslee, Fassler, David, & Lash, Michelle. (1985). *The Divorce Workbook.* (Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32757 1-800-892-KIDS.)

Workbook for children to help express feelings associated with separating and divorce. Ages 4-12.

Freed, Alvyn & Margaret. (1983). *TA for TOTS, TA for TOTS II, TA for Kids.* (Jalmer Press, 45 Hitching Post Drive, Building 22A, Rolling Hills Estates, CA 90274.)

To help children/adolescents feel OK by understanding their feelings and the feelings of others. TA = Transactional Analysis. *TA for Kids* is for elementary age, *TA for TOTS* for preschool.

Freeman, Lory. (1984). *It's My Body, A Book To Teach Young Children How to Resist Uncomfortable Touch.* Seattle: Parenting Press. (Network Publications, 1700 Mission Street, Suite 203, P.O. Box 1830, Santa Cruz, CA 95061-1830 408/429-9822.)

Simple text and attractive illustrations help adults teach preschoolers two "touching codes." A parent's guide by Janie Hart-Rossi called Protect Your Child From Sexual Abuse is also available. Preschool.

Holcomb, Nan. *How About A Hug.* (Ednick Communications, Inc., P.O. Box 3612, Portland, OR 97208 503/246-4601.)

Experiences of a little girl with Down Syndrome; designed to entertain children with similar lifestyles, but can be enjoyed by all children and used as an awareness tool. Preschool, elementary.

Hutchinson, Barbara & Chevelier, Elizabeth. (1982.) *My Personal Safety Coloring Book.* (Fridley Police Department, 6431 University Avenue N.E., Fridley, MN 55432 612/571-3457.)

Teaches concepts of good and bad touching through pictures to be colored with sad or happy faces drawn in, depending on the touch. Good questions about feelings associated with the pictures. Preschool through third grade.

Kehoe, Patricia. (1987). *Something Happened and I'm Scared to Tell.* (Parenting Press, Inc. 11065 5th Avenue NE, Seattle, WA 98125.)

Who is a suspected victim of sexual/physical abuse? Focuses on rebuilding the self-image of the child. Ages 3-7.

Kent, C. (1980). The Touch Continuum. *Child Care Resources*, 4 (2), 1-5. (Hennepin County Attorney's Office, Child Sexual Abuse Prevention Project, C-2100 Government Center, Minneapolis, MN 55487 612/348-3091.)

Defines the entire spectrum of touching, from lack of touch to exploitive touch.

Kidsrights. *A Little Bird Told Me About My Feelings.* (Kidsrights, 3700 Progress Blvd. Mt. Dora, FL 32757 1-800-892-KIDS.)

A story and coloring book which helps children say no to inappropriate touching by trusting their own feelings. Ages 4-10.

Kidsrights. *Loving Touches.* (Kidsrights, 3700 Progress Blvd. Mt. Dora, FL 32757 1-800-892-KIDS.)

Teaches respect for one's own and others' bodies; informs children about caring and appropriate kinds of touch. Ages 3-8.

Lalli, Judy. *Feelings Alphabet.* Rolling Hills Estates, CA: Jalmer Press. (Jalmer Press, 45 Hitching Post Drive, Building 22A, Rolling Hills Estates, CA 90274.) Preschool, elementary.

Lash, Michelle, Fassler, David, & Loughridge, Sally Ives. (1990). *My Kind of Family.* Mt. Dora, FL: Kidsrights. (Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32357 1-800-892-KIDS.)

For kids in single-parent homes; designed to help children express and understand issues and feelings associated with single-parent households. Ages 4-12.

Lexington Center, Inc. (1986). *No-Go-Tell.* (Lexington Center Foundation/Lexington School for the Deaf, 30th Avenue and 75th Street. Jackson Heights, NY 11370 718/899-8800.)

A child protection curriculum designed specifically for preschool and early elementary-age children with disabilities.

Mackey, Gene & Swan, Helen. (1985). *The Wonder What Owl.* (Children's Institute of Kansas City, 9412 High Drive, Leawood, KS 66206.)

For parents and young children about child sexual abuse to help parents and children discuss this sensitive subject; adult section of further discussion of ideas. Preschool, elementary.

Mayle, Peter. (1977). *Where Did I Come From?* (Kidsrights, 3700 Progress Blvd. Mt. Dora, FL 32757 1-800-892-KIDS.)

The facts of life without nonsense; humorous presentation with honest answers and graphics. Ages 3-10.

Meyer, Linda D. *Safety Zone.* (Chas. Franklin Press, 7821 175th Street SW, Edmonds, WA 98020 206/774-697.)

Skills for children to prevent child abduction: hypothetical situations, safety tips, and games; text for adults includes information about what to do if your child is abducted. Ages 4-11.

Morgan, Marcia. (1984). *My Feelings.* (Network Publications, 1700 Mission Street, Dept. P., P.O. Box 8506, Santa Cruz, CA 95061-8506 408/429-9822.)

Sexual abuse information in the form of a coloring book; designed to teach children to identify and trust their own instincts about good and bad touch. Ages 4-10.

PACER Center, Inc. (1989). *Thoughts About My Child.* (PACER Center, 4826 Chicago Avenue South, Minneapolis, MN 55417.)

A booklet to help parents organize information, ideas, and goals for their preschool child with disabilities; available in Hmong, Spanish, and English.

Pankow, Valerie. (1987). *No Bigger Than My Teddy Bear.* (Special Needs Project, 1563 Solano Avenue, Suite 283, Berkeley, CA 94707 415/525-8544.)

For siblings of premature newborns: a former teacher tells the story of her own family and her young son's reaction to his premature brother.

Planned Parenthood of Smohomish. (1982). *"It's My Body."* (Planned Parenthood of Smohomish, 2730 Hoyt Avenue, Everett, Washington 98201.)

Accompanying parent guide.

Sewes. (1985). *Sign Language Feelings.* (Special Needs Project, 1563 Solano Avenue, Suite 283, Berkeley, CA 94707 415/525-8544.)

An educational coloring book for preschool and elementary children.

Simon, Norma. (1976). *All Kinds of Families.* (Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32757 1-800-892-KIDS.)

Embracing the full spectrum of families: nuclear, traditional, adoptive, racial, and divorced households are represented. Ages 5-8.

Stowell, Jo & Dietzel, Mary. (1980.) *My Very Own Book About Me.* (Lutheran Social Services of Washington, Rape Crisis Resource Library, N. 1226 Howard, Spokane, WA 99201 509/327-7761.)

A tool for diagnosing, preventing, and treating child sexual abuse; a workbook that uses a positive, experiential approach. Comes with a parent guide; guides for teachers and therapists also available. Preschool through sixth grade.

Wachter, Oralee. (1983). *No More Secrets For Me.* Boston: Little Brown and Co.

Four separate stories on the theme of sexual abuse of children; young victims are able to articulate their feelings with the help of a person they trust.

Wakcher, Bridget. *Child Abuse—Is It Happening to You?* (Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32757 1-800-892-KIDS.).

Tells children what basic needs should be met by parents; approaches difficult situations through illustrations of what is not acceptable behavior by parents and other adults. Ages 3-8.

Kidsrights. *What If I Say No.* (Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32757 1-800-892-KIDS.).

Wehman, Barbara & Gulczynski, Lydese. (1983). *Thumbbody and the Touching Problem.* (Cooperative Educational Service Agency #4, Human Growth and Development Program, P.O. Box 728, Cumberland, WI 54829.)

Created for parents to read with their children to protect them from inappropriate touch. Preschool, elementary.

Williams, J. (1980). *Red Flag Green Flag People.* (Rape and Abuse Crisis Center, P.O. Box 1655, Fargo, ND 58107 701/293-7273.)

A coloring book with self-protection information; examples of good touch and bad touch through the use of "red flag" or "green flag" people. Preschool through third grade.

Additional Resources for Professionals and Families

The following resources are included in addition to the References listed at the end of each section.

RESOURCES FOR CHILD-CARE PROVIDERS

Heidemann, S. (1989). *Caring for At-Risk Infants and Toddlers in a Family Child Care Setting.* Minneapolis, MN: University of Minnesota, Early Childhood Studies Program. (Available from Early Childhood Studies, University of Minnesota, 201 Wesbrook Hall, 77 Pleasant Street SE, Minneapolis, MN 55455.)

Heidemann, S. & Koskie, B. (1988). *Working with the Abused and Neglected Child in a Family Day Care Setting.* Minneapolis, MN: Greater Minneapolis Day Care Association. (Available from the Greater Minneapolis Day Care Association, 1628 Elliot Avenue South, Minneapolis, MN 55404 612/341-1177.)

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Ragan, C.K. (November, 1986). *Child Abuse and Neglect in Day Care.* Washington, D.C.: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. (Available from the Clearinghouse on Child Abuse and Neglect Information, P.O. Box 1182, Washington, D.C. 20013 703/881-2086.)

RESOURCES ABOUT CHILDREN WITH DISABILITIES

Cole, S.S. (Fall/Winter 1984-1986). Facing the Challenges of Sexual Abuse in Persons with Disabilities. *Sexuality and Disability,* 7(3/4), 71-87.

Garfinkel, L., & Gorka, C. (1988). *PACER Center's Description of Children with Disabilities: A Silent Statistic in Child Abuse Literature.* Minneapolis, MN: PACER Center. (Available from PACER Center, 4826 Chicago Avenue South, Minneapolis, MN 55417.)

Kline, D.F. & Kline, A.C. (1987). *The Disabled Child and Child Abuse.* Chicago, IL: National Committee for Prevention of Child Abuse (NCPCA). (Available from NCPCA, Publishing Department, 332 S. Michigan Avenue, Suite 950, Chicago, IL 60604-4357 312/663-3520.)

McMahon, P. (1988). *A Resource Manual on the Prevention of Abuse of Young Children.* Cincinnati, OH: Tri-State Organized Coalition for Persons with Disabilities. (Available from Child Advocacy Center, 106 Wellington Place, Cincinnati, OH 45219 513/381-2400.)

PACER Center, Inc. (1989). *Let's Prevent Abuse: An Information Guide for Educators.* Minneapolis, MN: Author. (Available from PACER Center, 4826 Chicago Avenue South, Minneapolis, MN 55417.)

Sullivan, P.M., McKay, V., & Scanlan, J. (October, 1987). Sexual Abuse of Deaf Youth. *A.D.D.*, pp. 256-262.

Zirpoli, T.J. (1986). Child Abuse and Children with Handicaps. *RASE*, 7(2), 39-48. (Available from *RASE*, 5341 Industrial Oaks Boulevard, Austin, TX 78735.)

RESOURCES ABOUT CULTURAL DIVERSITY

Anderson, P.P. & Fenichel, E.S. (1989). *Serving Culturally Diverse Families of Infants and Toddlers with Disabilities.* Arlington, VA: National Center for Clinical Infant Programs (NCCIP). (Available from NCCIP, 2000 Fourteenth Street, North, Suite 380, Arlington, VA 22201-2500 703/528-4300.)

A Bibliography of Selected Resources on Cultural Diversity for Young Children Who Have, or Are at Risk for, Disabilities. (1989). Chapel Hill, NC: NEC*TAS. (Available from PACER Center, 4826 Chicago Avenue South, Minneapolis, MN 55417.)

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Toward a Culturally Competent System of Care.* National Institute of Health, Child and Adolescent Service System Program (CASSP). (Available from CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road NW, Washington, D.C. 20007 202/687-8645.)

Cross, T.L. (Fall, 1988). Cultural Competence Continuum. *Focal Point*, 3(1), 1-3. (Also included in *Toward A Culturally Competent System of Care*—see above.)

Departamento de Educacion de Arizona. (1989). *Para Los Padres: Como Se Desarrolla Sue Bebe Desde El Nacimiento Hasta Los 5 Años.* Phoenix, AZ: Arizona Department of Education.

Ethnic and Multicultural Bulletin. The *Bulletin* is published two to three times a year by the Council for Exceptional Children, Office of Ethnic and Multicultural Concerns. (Office of Ethnic and Multicultural Concerns, The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091-1589 703/620-3660.)

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Through the Eyes of the Child. First-person accounts. DOO1ACA90.

Parenting—The World's Toughest Job. Helping parents deal with stress. DOO1BCA90.

Hush Little Baby. Professionals discuss the mother/child relationship. DOO1CCA90.

The Adolescent Self. Counselors and teenagers explain how long-term abuse can lead to delinquency and other problems. DOO1DCA90.

Stolen Childhood. Families and professionals explore how and why children are sexually abused and what they can do to protect themselves. DOO1ECA90.

Out of Harm's Way. Child protection professionals describe the complexities of safeguarding children against abuse and neglect. DOO1FCA90.

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Child Abuse Hurts . . . Everyone

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Sibling Abuse

Tell Someone: For Adults Who Were Sexually Abused as Children

Brochures from PACER Center:

Available from PACER Center, 4826 Chicago Avenue South, Minneapolis, MN 55417.

Child Abuse and the Vulnerability of Children with Disabilities

Discussing Possible Abuse with a Child: Guidelines

Brochures from Resources for Child Caring:

Available from Resources for Child Caring, 450 North Syndicate, Suite 5, St. Paul, MN 55104 612/641-0305

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Taking Care of Yourself in a Caretaking Profession

Children Who Bite
Family/Children in Care: When Needs Conflict
Multi-Age Care: An Enriching Experience
Reporting Abuse and Neglect
Children with Extra Needs
Children and Sexual Behavior: What's Appropriate?
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LET'S PREVENT ABUSE

A Prevention Handbook for Early Childhood Professionals and Families with Young Children, with Special Emphasis on the Needs of Children with Disabilities

was prepared by PACER Center's (Parent Advocacy Coalition for Educational Rights) LET'S PREVENT ABUSE Project

PACER Center is a coalition of 19 disability organizations and serves as the parent training and information center for Minnesota. Founded on the concept of Parents Helping Parents, PACER's mission is to improve and expand opportunities that enhance the quality of life for children and young adults with disabilities and their families.